

Deseret Mutual Benefit Administrators

BRIGHAM YOUNG UNIVERSITY – HAWAII

Student Health Plan 2007-2008

Offered by: Deseret Mutual Insurance Company
Administered by: Deseret Mutual Benefit Administrators



BYU-HAWAII STUDENT HEALTH PLAN SUMMARY OF BENEFITS

Student Health Center	You and your covered dependents must use the Student Health Center (SHC) as your primary care provider. Covered services at the SHC are paid at 100% after your \$10 copayment. Any service provided outside the SHC requires a referral from the SHC and preauthorization from Deseret Mutual.	
Referrals	If you or your covered dependents need to see a specialist outside the SHC, you must obtain a referral from the SHC before making an appointment with the specialist. This referral from the SHC will automatically initiate a request for preauthorization with Deseret Mutual.	
Preauthorization	You must preauthorize all services outside the SHC, except emergency room visits. If you are referred by the SHC, the preauthorization is requested automatically. Otherwise, you must contact Deseret Mutual at 1-808-293-3972 before you receive the medical care (see page 9).	
Copayments	SHC: \$10 for regular visits and \$15 for urgent care visits. Outside the SHC: \$25 per service for physician, urgent care, and other outpatient care (\$100 per service that is not preauthorized); \$50 for hospital emergency room visits; \$200 per hospital admission (\$300 per hospital admission that is not preauthorized).	
Maximum Benefit	There is a maximum benefit of \$30,000 per person per academic year for services outside the SHC. For coverage of medical expenses above the maximum benefit, refer to BYU-Hawaii's Large Claims Coverage (see page 20).	
Explanation of Covered Expenses	Plan payments are subject to maximum allowable charges, determined by Deseret Mutual (see page 3).	
	Covered Services	Contracted Provider
	Non-Contracted Provider	
Hospital Medical Services: Semi-private room, surgical services & supplies, outpatient medical care	80% of allowable charges after copayment	50% of allowable charges after copayment
Ambulatory Surgical Center: Outpatient surgery, services, & supplies	80% of allowable charges after copayment	50% of allowable charges after copayment
Physician Medical Services: Office visits, hospital visits, surgeon, surgical assistant, and anesthesiologist	80% of allowable charges after copayment	50% of allowable charges after copayment
Emergency Care: Emergency room services & supplies	80% of allowable charges after copayment	
Home Health Care: Services & supplies from a home health agency	80% of allowable charges after copayment	50% of allowable charges after copayment
Durable Medical Equipment: Rental or purchase of DME (see page 15)	80% of allowable charges after copayment	50% of allowable charges after copayment
Maternity Care*: <ul style="list-style-type: none"> • Hospital and ancillary services • Physician office visits (Married student and married student with maternity coverage for non-student spouse see pages 13 to 14)	<ul style="list-style-type: none"> • 80% of allowable charges after copayment • 80% of allowable charges after \$25 copayment per visit to a maximum of \$150 for routine care 	<ul style="list-style-type: none"> • 50% of allowable charges after copayment • 50% of allowable charges after \$25 copayment per visit to a maximum of \$150 for routine care
Diagnostic X-ray & Lab Services: CT, MRI, ultrasound, lab, and pathology	80% of allowable charges	50% of allowable charges
Outpatient Therapy: Radiation therapy, chemotherapy, and dialysis (See pages 11 and 17)	80% of allowable charges after copayment	50% of allowable charges after copayment
Physical Therapy (See page 17)	100% of allowable charges after \$10 copayment	50% of allowable charges after \$25 copayment
Ambulance: Licensed land or air transport	80% of allowable charges after copayment	50% of allowable charges after copayment
Prescription Drugs <ul style="list-style-type: none"> • Mail service • Retail pharmacy 	<ul style="list-style-type: none"> • 80% for formulary drugs • 70% for formulary drugs 	<ul style="list-style-type: none"> • 50% for non-formulary drugs • 50% for non-formulary drugs

*Maternity coverage is included for all students / policyholders. Non-student spouses may purchase coverage as a dependent with or without maternity coverage. This summary of benefits provides a brief review of plan benefits. For complete details of coverage, including limitations and exclusions, please read this entire Student Health Plan Handbook.

Who to Contact

Student Insurance Office

Enrollment, Premium, & Coverage Information	1-808-293-3512
Fax	1-808-293-3657
Deseret Mutual	1-808-293-3970
Enrollment, Premium, & Coverage Information	1-808-293-3970
	1-808-293-3512
Deseret Mutual Preauthorization	1-808-293-3972
SHC Appointment Scheduling & Referrals.	1-808-293-3510
SHC After-hours Emergencies (On-call Nurse)	1-808-293-3911

Addresses

Student Health Center:

BYU-Hawaii #1916
55-220 Kulanui Street
Laie, Hawaii 96762

Student Insurance Office:

BYU-Hawaii #1950
55-220 Kulanui Street
Laie, Hawaii 96762

Deseret Mutual:

BYU-Hawaii #1972
55-220 Kulanui Street
Laie, Hawaii 96762

To contact Deseret Mutual online, go to:

www.dmba.com/sc/dmbaemail.asp

Deseret Mutual's Preferred Provider Network

Hawaii: MDX (formerly, Queen's Health Care Plan Network)
1-808-293-3970

Idaho & Utah: Deseret Mutual Contract Providers
1-800-777-3622 or www.dmba.com/nsc/medical/provpick.htm

All other states: First Health Medical Network
1-800-237-5702 or www.firsthealth.com

Access the Student Health Plan Handbook:

www.dmba.com/nsc/student/handbooks.htm

CONTENTS

<u>To All Students</u>	1
<u>BYU-Hawaii Student Health Plan for 2007-2008</u>	2
<u>Important Keys to Remember</u>	2
<u>How does the Student Health Plan work?</u>	2
<u>How are medical services paid?</u>	3
<u>Who is eligible to enroll?</u>	4
<u>When may I enroll?</u>	4
<u>Can I change my enrollment midyear?</u>	4
<u>What about internships and performing groups?</u>	5
<u>What about short breaks from school?</u>	5
<u>What if I go on a mission?</u>	5
<u>Can I continue my enrollment after I leave BYU-Hawaii?</u>	5
<u>Coverage Options</u>	6
<u>What is “Away-from-Campus Coverage”?</u>	6
<u>How does Away-from-Campus Coverage work?</u>	6
<u>What is “Extended Coverage”?</u>	6
<u>How does Extended Coverage work?</u>	7
<u>How do I enroll in Extended Coverage?</u>	7
<u>When does coverage begin?</u>	7
<u>When does coverage end?</u>	7
<u>What if I visit another Church university?</u>	8
<u>What are the Student Health Plan premiums?</u>	8
<u>When are premiums due?</u>	9
<u>Discounted Dental</u>	9
<u>What medical services are available at the SHC?</u>	9
<u>When is the SHC open?</u>	9
<u>Services Outside the SHC</u>	9
<u>What services are covered outside the SHC?</u>	10
<u>Alcohol and Chemical Dependency</u>	10
<u>Allergy Services</u>	10
<u>Ambulance (Land and Air)</u>	10
<u>Anesthesia</u>	10
<u>Chemotherapy</u>	11
<u>Dental Accident Benefit</u>	11
<u>Diabetes Education</u>	11
<u>Diabetic Supplies</u>	11
<u>Dialysis</u>	11
<u>Emergency Room</u>	11
<u>Eye Exams</u>	11
<u>Food Supplements</u>	12
<u>Home Health Care</u>	12

<u>Immunizations for Children</u>	12
<u>Infertility</u>	12
<u>Injections (Allergy, Intramuscular, etc.)</u>	12
<u>Inpatient Hospital Services</u>	12
<u>Inpatient Physician Services</u>	13
<u>In Vitro Fertilization</u>	13
<u>Laboratory Services</u>	13
<u>Maternity</u>	13
<u>Maternity — Hospitalization</u>	14
<u>Maternity — Physician / Nurse-Midwife Services</u>	14
<u>Medical Equipment (Durable)</u>	15
<u>Medical Supplies</u>	16
<u>Mental Health Therapy</u>	16
<u>Office Visits</u>	16
<u>Pain Clinics</u>	16
<u>Physical Therapy — Outpatient</u>	17
<u>Prescription Drugs</u>	17
<u>Prosthetics</u>	17
<u>Radiation Therapy</u>	17
<u>Radiology Services (Mammograms, X-rays, CT Scans, MRIs, etc.)</u>	18
<u>Surgery — Inpatient Hospital Services</u>	18
<u>Surgery — Outpatient Hospital Services</u>	18
<u>Surgery — Physician Services</u>	18
<u>Well Baby Care</u>	18
<u>Are there services the plan does not cover?</u>	18
<u>What is Deseret Mutual's Preferred Provider Network?</u>	18
<u>What should I do in an emergency?</u>	19
<u>What about follow-up to emergency care?</u>	19
<u>How do I submit a claim for payment?</u>	19
<u>Large Claims Coverage</u>	20
<u>Repatriation of Remains</u>	20
<u>Exclusions</u>	20
<u>Legal Notice</u>	23
<u>Claims Review Procedures</u>	23
<u>Coordination of Benefits</u>	25
<u>Subrogation</u>	25
<u>Notification of Benefit Changes</u>	25
<u>Notification of Discretionary Authority</u>	25
<u>Fraud Policy Statement</u>	25
<u>Important Dates</u>	26
<u>Definitions</u>	26
<u>Index</u>	30

To All Students

The costs of medical care and hospitalization continue to increase at an alarming rate. An accident, unexpected illness, or hospitalization can result in a significant financial burden to you, your family, and the community. Medical coverage provides a way to help defray some of these costs as they arise. Many providers in Hawaii do not accept mainland insurance plans and may require full payment at the time of service.

The BYU-Hawaii Student Health Plan offers a wide range of benefits. Coverage for students' spouses and children is also available.

Insurance Requirement

BYU-Hawaii requires all full-time continuing students to have adequate medical coverage for the duration of their enrollment at BYU-Hawaii. In other words, you must have coverage the entire time you are a continuing BYU-Hawaii student, including during any summers you take off or other short-term breaks from classes.

To satisfy the University's requirement, you must enroll in either the BYU-Hawaii Student Health Plan or a group medical plan provided by your employer or your spouse's or parent's employer. For any other medical plan to meet this requirement, it must:

- Provide at least 80 percent coverage for all major medical expenses, including physician, hospital, and ancillary services
- Have an individual annual deductible of no more than \$500
- Have an annual plan limit of no less than \$25,000
- Include medical care and treatment in Hawaii

If you choose a medical plan other than the Student Health Plan, you must complete an online waiver verification form showing adequate coverage at the beginning of your first semester/term and at the beginning of each academic year thereafter (fall semester). Any changes in your private plan must also be reported to the insurance office. The BYU-Hawaii Insurance Office is located in the Lorenzo Snow Administration Building at 55-220 Kulanui Street #1950.

Students enrolled for 9 or more credit hours per semester or 4.5 or more credit hours per term who do not properly complete an online waiver form as indicated above will be enrolled automatically for individual coverage and assessed the appropriate premium. For semester and term waiver deadlines, see [Important Dates](#) beginning on page 26 of this handbook.

Spouses and dependents will not be enrolled automatically the first semester or term that you are on the plan. If you want coverage for your spouse and dependents, you must come in to the insurance office and enroll them in the plan by completing a student insurance enrollment form.

Student insurance enrollment, waiver, and verification forms are available online or at the Student Insurance Office. Our office is located at the IWES Student Employment and Insurance Department in the Lorenzo Snow Administration Building.

If you drop below full-time status at any time during the academic year you will be enrolled in Away-from-Campus Coverage (see [page 6](#)). Remember, you are required to have coverage while you are enrolled as a continuing full-time student.

For information about BYU-Hawaii's Student Health Plan visit the Student Insurance Web site at <http://w3.byuh.edu/studentlife/employment/insurance.html> or by clicking University Services, Employment for Students, and Insurance on the byuh.edu Web site. If you would like to make an appointment with a Student Insurance representative please call the Student Insurance Office at 1-808-293-3512.

BYU-Hawaii Student Health Plan for 2007-2008

The Student Health Plan offered by BYU-Hawaii provides a wide range of basic medical coverage. The plan is underwritten by Deseret Mutual Insurance Company (DMIC) and administered by Deseret Mutual Benefit Administrators (Deseret Mutual), based in Salt Lake City, Utah.

Medical expenses that are covered by the plan include those incurred for medically necessary treatment of injury or illness, within the plan contract limitations. See the appropriate sections of this handbook for more information about eligible charges and coverage limitations (beginning on [page 9](#)).

This Student Health Plan handbook will provide you with a summary of plan benefits, as well as information about how the plan works. Please review this information carefully. **To receive the benefits available to you, it is your responsibility to become familiar with the plan provisions and guidelines. Please be aware, exceptions to the plan's contractual provisions cannot be granted.**

Important Keys to Remember

- **The Student Health Center (SHC) is your primary source of medical care. Always consult the SHC first.**
- In an emergency, you should always get the appropriate care immediately. Please see [page 19](#) for information about what to do in an emergency.
- As a participant in the plan, Deseret Mutual will assign you a unique identification number. This Deseret Mutual ID number is your policy number. A Student Health Plan ID card will be sent to you after you enroll in the plan. After you receive your ID card, present it to the provider at the time of service. If you require medical services before you receive your ID card, give the provider your Deseret Mutual ID. Contact Deseret Mutual if you do not receive your ID card within six weeks of your first day of class or if you have lost your card.
- Preauthorization from Deseret Mutual is required before you receive care outside the SHC. A referral from a physician outside the SHC does not constitute preauthorization. You must contact Deseret Mutual at 293-3972 to preauthorize services outside the SHC. However, if you are referred by an SHC physician, preauthorization will occur automatically.
- Always receive care from providers who are contracted through Deseret Mutual's Preferred Provider Network. If you used non-contracted providers, your benefits may be lower. See [page 18](#) for information on the Preferred Provider Network.
- If you use non-contracted providers, you will be responsible to pay any charges that exceed maximum allowable amounts
- **New dependents must be enrolled within 60 days of the qualifying event (marriage, birth, or adoption placement). Notify the Student Insurance Office immediately of any newborn dependents or other changes to your coverage.**
- Not all services are covered by the plan. Please read the [exclusions](#) beginning on page 20 carefully to see which services are not covered.
- Your student account will be charged the appropriate premium (based on the coverage option you choose) at the beginning of each semester and term during the academic year. This includes spring and summer terms.

How does the Student Health Plan work?

All eligible care is provided by or coordinated through the SHC. If you need eligible services that the SHC cannot provide, you will be referred to contracted medical providers in the community. These providers have contracted with Deseret Mutual to offer care at a reduced cost to participants. The discounts will be reflected in the portion of charges that you are responsible to pay.

Annual Enrollment Requirement

BYU-Hawaii has an annual enrollment requirement for the Student Health Plan. This means that when you enroll, you enroll for the entire school year. You may waive the Student Health Plan if you gain private insurance (waiver forms are available online or at the Student Insurance Office).

If you don't enroll for classes for one semester but intend to return for the following semester, the University requires you to maintain your enrollment in the Student Health Plan. If you are leaving school for two or more semesters, you may enroll in Extended Coverage (see page 6).

How are medical services paid?

When you receive care outside of the SHC, you pay a **copayment** to the provider of the care at the time you receive the service. This is a fixed dollar amount. After your copayment, the amount covered by the plan is your **plan benefit**, and the amount you pay is your **coinsurance** amount.

When you receive services, you or the provider of the care must submit an itemized bill to Deseret Mutual (see [page 19](#)). Deseret Mutual will process your claim, send a check for the plan benefit to the provider of the care, and send you an **explanation of benefits** statement. This statement will itemize the charges, your deductible (if applicable), your copayment, the plan benefit, and your coinsurance. You pay your copayment to the provider of the care at the time of service, and you pay coinsurance later when you receive the bill.

In some cases, the provider of the care will bill more than Deseret Mutual's **maximum allowable limit** for the services given. If so, your explanation of benefits statement will also itemize how much of the bill is **over the maximum allowable limit**.

- If you receive your care from one of Deseret Mutual's **contracted providers**, you do not need to pay any amount over the maximum allowable limit. When health-care providers contract with Deseret Mutual, they agree not to bill you for more than the maximum allowable amount. (See [page 18](#) for information about contracted providers).
- If you receive your care from a provider who is **not contracted** with Deseret Mutual, **you will be billed for any charges that exceed the plan's maximum allowable amount**. It then becomes your responsibility to pay those additional charges.

You are also responsible to pay the provider of your care for any services which are not covered by the plan.

Your Copayments

For eligible physician services you receive at the SHC, including office visits and emergency care, your copayments are:

- \$10 during regular clinic hours
- \$15 for after-hours visits

For authorized services you receive outside the SHC, your copayments are:

- \$25 per service for physician services and other outpatient care
- \$50 for hospital emergency room visits
- \$200 per hospital admission (\$50 for newborn infants)
- **If you do not preauthorize services you receive outside the SHC when necessary, you pay an additional \$100 copayment per service**

As you can see, it is very important to preauthorize services you receive outside the SHC.

Amount Paid By the Student Health Plan and Your Coinsurance

After you have paid your **copayment**, benefits for the remainder of eligible expenses are:

	The Plan Pays:	You Pay:
Services at the SHC	100%	0%
Services Outside the SHC	Contracted providers: 80% Non-contracted providers: 50%	Contracted providers: 20% Non-contracted providers: 50%

Remember, benefits for all care received outside the SHC are based on the lesser of billed charges, contracted rates, or maximum allowable charges for the services received, as determined by Deseret Mutual. And, for all services, the guidelines, benefits, and exclusions of the plan will determine claims payment.

The maximum benefit for all services received outside the SHC is \$30,000 per person per academic year. For expenses that exceed the plan maximum, please see the information on [page 20](#) about BYU-Hawaii's Large Claims Coverage.

Who is eligible to enroll?

Students: You may enroll in the BYU-Hawaii Student Health Plan if you are a full-time continuing student, as defined by BYU-Hawaii.

Dependents: If you enroll in the Student Health Plan, you may also enroll your eligible dependents, including:

- Your legal spouse or certified reciprocal beneficiary.
- Your unmarried children younger than 26. You may apply for an exception to the age limit if you have a child who is incapable of self support because of a mental or physical handicap that began before age 26. You must submit proof of the incapacity within 31 days of your child's 26th birthday.

You may purchase dependent coverage with or without maternity coverage for your non-student spouse.

When may I enroll?

You may enroll in the Student Health Plan, either for individual or family coverage, at the beginning of your first semester/term as a full-time student at BYU-Hawaii. Your membership in the plan is renewed automatically each academic year unless you drop below full-time status or personally notify the Student Insurance Office.

You must submit your online enrollment application for new coverage before the enrollment deadlines specified in the [calendar](#) beginning on page 26.

Please note, all full-time continuing students who do not provide verification of other insurance that meets BYU-Hawaii's requirements will be enrolled automatically in the Student Health Plan for individual coverage and will be assessed the appropriate premium. Verification and waiver forms should be submitted to the Student Insurance Office by the [deadlines](#) listed beginning on page 26.

Can I change my enrollment midyear?

If you enroll for individual coverage and do not enroll your dependents, you may not add them to your coverage midyear; you must wait until the beginning of the next academic year to do so.

However, if you acquire a new dependent because of marriage or the birth or adoption of a child, you may enroll in the plan or change your enrollment to include coverage for your new spouse and/or the new dependent as long as you apply to do so within 60 days of this event. If you do not enroll your dependents within this 60-day window, you will have to wait until the beginning of the next academic year (fall semester) to enroll them.

Newborn dependents will be covered for care and treatment of medically diagnosed congenital defects and birth abnormalities from the date of birth for 31 days. To receive this coverage, you must add the newborn to your Student Health Plan policy.

Adopted newborn dependents will be covered as follows:

- Newborn dependents will be covered for care and treatment of medically diagnosed congenital defects and birth abnormalities from the date of birth for 31 days
- Adopted newborn dependents who are not newborns will be covered automatically from the date of placement for 31 days

If you waive enrollment in the Student Health Plan for yourself and/or your dependents because you have other coverage that meets BYU-Hawaii's requirements, and you subsequently lose eligibility to continue the other coverage, you may enroll in the Student Health Plan for yourself and/or your dependents if you apply within 31 days of losing eligibility for the other coverage.

If you enroll in the Student Health Plan and subsequently obtain other insurance that meets BYU-Hawaii's requirements, you may discontinue your enrollment in the Student Health Plan at the end of your current semester or term. To do so, submit a waiver form and certification of the other coverage to the Student Insurance Office by the [deadlines](#) listed beginning on page 26.

What about internships and performing groups?

If you are enrolled in the Student Health Plan and you participate in an internship required by your department or you travel as a member of a BYU-Hawaii performing group on tour, you will be covered by the Away-from-Campus option of the Student Health Plan during that semester/term unless you submit a waiver as proof of other coverage. Please see [What is "Away-from-Campus Coverage"?](#) on page 6 for more information.

What about short breaks from school?

If you enroll in the Student Health Plan for the academic year and then decide to take a semester or term off by not enrolling in classes full-time, but you do not withdraw from the University or otherwise lose your status as a continuing student, you will be covered by the Away-from-Campus option of the Student Health Plan during that semester/term. Please see [What is "Away-from-Campus Coverage"?](#) on page 6 for more information.

What if I go on a mission?

If you leave BYU-Hawaii to serve a mission, you will not be covered by the Student Health Plan during your mission. You may re-enroll when you return to BYU-Hawaii.

Can I continue my enrollment after I leave BYU-Hawaii?

Yes, within certain limitations. Please see [What is "Extended Coverage"?](#) on page 6.

Coverage Options

There are three coverage options within the Student Health Plan. You will be enrolled in the appropriate option, based on your student status. You should be aware that plan requirements may be different in each option. These differences are noted in this plan handbook.

The benefits for services received outside the SHC are the same for all coverage options. All services received outside the SHC, other than emergency care, require preauthorization.

If you are:	Your coverage option is:
Enrolled in classes on campus full-time	Regular On-Campus coverage
Enrolled in an internship required for your degree, or on tour as part of a BYU-Hawaii performance group	Away-from-Campus coverage (See below)
Admitted as a continuing student but taking a semester or term off (or enrolled in classes for less than full-time)	Away-from-Campus coverage (See below)
Graduated, or withdrawn from school	Extended Coverage (Optional: separate enrollment required) (See below)

What is “Away-from-Campus Coverage”?

The Away-from-Campus option of the Student Health Plan provides insurance coverage for students who drop below full-time status or who are temporarily off Oahu and therefore do not have access to the SHC.

You are required to enroll in the Away-from-Campus option if you:

- Participate in an internship required by your department.
- Travel as a member of a BYU-Hawaii performing group on tour.
- Take a temporary break from enrollment in classes on campus (for example, if you take the summer off) but do not withdraw from the University or otherwise lose your status as a continuing student.

If you have enrolled your dependents in the plan for the academic year, they will also be covered by this option while you are. You may make changes to your enrollment (add dependents, discontinue coverage, etc.) only as outlined on [page 4](#).

How does Away-from-Campus Coverage work?

While you are enrolled in the Away-from-Campus option, you may receive your medical care from any qualified, appropriately licensed medical provider. However, it will be to your advantage to use providers who are part of Deseret Mutual’s national Preferred Provider Network whenever possible (please see [page 18](#)). Also, you may still receive medical care at the SHC if you are on Oahu. **You will still need to preauthorize any care you receive outside the SHC.**

What is “Extended Coverage”?

Your Student Health Plan coverage terminates at the end of the semester or term in which you graduate, withdraw from BYU-Hawaii, or otherwise lose your status as a continuing student.

If you were enrolled in the Student Health Plan during your last semester or term at BYU-Hawaii and you would like to continue your coverage after you leave school, you may enroll in Extended Coverage for up to nine consecutive calendar months.

Your dependents may be insured by Extended Coverage only if they were enrolled with you for family coverage during your last semester or term at BYU-Hawaii.

Also, you may purchase family coverage that includes maternity coverage for your non-student spouse only if you were enrolled in maternity coverage during your last semester or term at BYU-Hawaii.

You may add newly acquired dependents to your coverage only as outlined on [page 4](#). If adding a new dependent changes your coverage option and premium, the additional premium for the month in which the dependent became eligible must be included with the enrollment form.

How does Extended Coverage work?

While you are enrolled in Extended Coverage, you may receive your medical care from any qualified, appropriately licensed medical provider. However, it will be to your advantage to use providers who are part of Deseret Mutual's national Preferred Provider Network whenever possible (please see [page 18](#)). **You will still need to preauthorize any care you receive outside the SHC.**

How do I enroll in Extended Coverage?

Enrollment in Extended Coverage takes place on a month-by-month basis. You may enroll for up to nine consecutive calendar months.

To enroll, complete an Extended Coverage enrollment form and mail it and at least the first month's premium to Deseret Mutual headquarters before the end of your last semester or term at BYU-Hawaii. For mailing information, please refer to the back cover of this handbook.

To renew your coverage from month to month, submit your enrollment form and premium payment to Deseret Mutual **at least five working days before the end of the previous month of coverage**. Renewal applications that are not submitted within five working days of the end of the previous month will not be accepted. It is very important for you to meet these deadlines. If you do not renew your coverage in time, your coverage will end and you will not be eligible to re-enroll.

When does coverage begin?

You will be covered for illness and injury while you are traveling to school and during on-campus activities before the first day of classes. This coverage will be effective for up to seven days before you are due to report for classes or orientation.

	Graduation or Loss of Continuing Student Status	Loss of Eligibility for Dependent	Move to Other Available Insurance
Regular On-Campus or Away-from-Campus Coverage	End of last semester/term in school	End of semester/ term in which dependent becomes ineligible	Beginning of next semester/term
Extended Coverage	12:01 a.m. on the first day of the month after the last month for which premium was paid.		

When does coverage end?

The coverage option you choose (either individual or family coverage) will generally remain in effect until the end of the academic year, unless you notify the Student Insurance Office of a change in status. If you drop below full-time status, Regular On-Campus Coverage will end on the first day of the semester or term in which your status changes. You must enroll in the Away-from-Campus Coverage option for that semester or term.

Please see the [calendar](#) beginning on page 26 for the exact dates that coverage begins and ends for the 2007-2008 academic year.

After your coverage ends, you may request a Certificate of Creditable Coverage by calling Deseret Mutual. This is a document certifying the length of time you were covered by the Student Health Plan. When you enroll in another health plan, you may be able to present this certificate to reduce the length of time that pre-existing conditions can be excluded from coverage.

	You and Your Current Dependents	New Dependent (Marriage)	Newborn Dependent (Natural or Adopted)	Adopted Dependent (Non-newborn)
Regular On-Campus or Away-from-Campus Coverage	First day of classes for new semester/term	12:01 a.m. on the date of marriage*	Automatically covered from date of birth for 31 days for specific conditions**	Automatically covered from date of placement for 31 days**
Extended Coverage	12:01 a.m. on the first day of classes at BYU-Hawaii for the semester/term after you leave school	12:01 a.m. on the date of marriage*	Automatically covered from date of birth for 31 days for specific conditions**	Automatically covered from date of placement for 31 days**
Mid-Year Enrollment	First day of classes for the semester in which you enroll.			

* You must formally enroll your new spouse within 60 days of the marriage.

** **This automatic coverage only applies to medically diagnosed congenital defects and birth abnormalities.** If you want full coverage for your newborn, you must formally enroll your dependent within 60 days of the birth or placement. You will be charged a premium retroactive to the date of the baby's birth.

What if I visit another Church university?

If you receive services at the SHC of another Church university, the services will be covered as if you had received services outside the SHC and at the contracted provider benefit. See [pages 10 to 18](#) for coverage amounts. You will not need preauthorization.

What are the Student Health Plan premiums?

	Regular On-Campus and Away-from-Campus Coverage	Extended Coverage
Single Student Only	\$236/semester \$118/term	\$135/month
Married Student Only	\$276/semester \$138/term	\$162/month
Single Student with Dependents	\$812/semester \$406/term	\$288/month
Married Student with Dependent(s) WITHOUT Maternity Coverage for Non-student Spouse	\$1,116/semester \$558/term	\$553/month
Married Student with Dependent(s) WITH Maternity Coverage for Non-student Spouse	\$1,826/semester \$913/term	\$872/month

When are premiums due?

Premiums are due at the same time as tuition and other fees each semester or term. Premiums are charged to your student account automatically unless you have submitted a waiver form to the Student Insurance Office by the [deadlines](#) listed beginning on page 26.

If you qualify to change enrollment midyear, the premium will be due immediately when you enroll for the semester or term in which the enrollment change becomes effective.

Discounted Dental

A Discounted Dental program is available to all students. This program provides students with discounted prices on dental services. Contact the Student Insurance Office for more information.

What medical services are available at the SHC?

The SHC provides primary medical care, which includes most non-hospital care. This means the SHC's primary care physicians will provide most of your care. However, in some cases they may refer you to another contracted provider for specialty care.

The SHC has a staff of physicians and specialists who provide medical care in the following areas:

- Emotional & behavioral medicine
- Gynecology
- Internal medicine
- Medical equipment & supplies
- Orthopedics
- Pediatrics — immunizations and preventive care
- Sports medicine

The SHC provides some limited durable medical equipment and medical supplies. Medical equipment that is reusable, such as crutches, must be returned to the SHC. If you do not return the equipment, you will be charged a fee that covers the cost of the item.

Please note, some routine physical exams and services that are available at the SHC are not covered by the plan.

When is the SHC open?

The SHC's regular hours for all clinical services are:

- 8 a.m. to 5 p.m., Monday through Friday
- Wednesday afternoons are reserved for obstetrician visits

The SHC closes for all school observed holidays and for administrative purposes as needed. If you have an emergency and the SHC is closed, call BYU-Hawaii security at 293-3911.

Services Outside the SHC

The Student Health Plan covers hospitalization and many other specialized medical services that the SHC does not provide. If you need such services, you will be referred to a medical provider in the community.

Preauthorization

For services from another provider to be eligible for maximum plan benefits, you must receive preauthorization from Deseret Mutual before you receive the medical care. If you are referred by an SHC physician, this preauthorization will occur automatically.

If your referred provider recommends care that is not specified in the original authorization, you must contact Deseret Mutual before you receive the additional care. This includes additional office visits, tests at another facility, or consultation with another health-care provider.

If you receive medical care or hospitalization outside the SHC without preauthorization from Deseret Mutual, you must pay an additional \$100 copayment per service.

Even if you have preauthorization from Deseret Mutual to see an outside provider, the authorization does not guarantee payment for the treatment you receive. For all services, the guidelines, benefits, and exclusions of the plan will determine claims payment.

What services are covered outside the SHC?

Please refer to [pages 10 to 18](#) for information about the benefits payable for services outside the SHC. **Remember, all benefits are subject to maximum allowable limits determined by Deseret Mutual.**

The following are examples of the services the plan covers outside the SHC:

Alcohol and Chemical Dependency

- Contracted provider: The plan pays 80%; you pay 20%
- Non-contracted provider: The plan pays 50%; you pay 50%
- Up to 30 outpatient visits and 30 inpatient hospital days per person per academic year
- If you can be discharged from an inpatient acute care setting to a less expensive alternative care setting (day treatment or partial day treatment) without compromising the quality of care, you may qualify for a maximum of 60 days per academic year. Residential treatment is not covered
- Any prior inpatient days will be applied to your maximum 60-day alternative care benefit with one inpatient day equaling two alternative care days
- You must preauthorize

Allergy Services

- Contracted provider: The plan pays 80% after your \$25 copayment; you pay 20%
- Non-contracted provider: The plan pays 50% after your \$25 copayment; you pay 50%
- You must preauthorize

Ambulance (Land and Air)

- When medically necessary, the plan covers licensed ambulance services to the nearest medical facility equipped to furnish the appropriate care
- The plan pays 80% after your \$25 copayment; you pay 20%

Anesthesia

- The plan pays 80%; you pay 20%

Chemotherapy

- Contracted provider: The plan pays 80%; you pay 20%
- Non-contracted provider: The plan pays 50%; you pay 50%
- You must preauthorize

Dental Accident Benefit

- Contracted provider: The plan pays 80% after your \$25 copayment; you pay 20%
- Non-contracted provider: The plan pays 50% after your \$25 copayment; you pay 50%
- The maximum benefit is \$3,000 per plan year
- Benefits apply only to services made necessary as a direct result of a traumatic accidental injury (such as a car accident or a facial injury) that occurs while you are covered by the plan
- Benefits apply only to services received while you are insured by the plan and within two years of the accident.
- You must preauthorize

Diabetes Education

- Contracted provider: The plan pays 80% after your \$25 copayment; you pay 20%
- Non-contracted provider: The plan pays 50% after your \$25 copayment; you pay 50%
- The maximum benefit is \$300 per plan year
- You must preauthorize

Diabetic Supplies

- Contracted provider: The plan pays 80%; you pay 20%
- Non-contracted provider: The plan pays 50%; you pay 50%

Dialysis

- Contracted provider: The plan pays 80%; you pay 20%
- Non-contracted provider: The plan pays 50%; you pay 50%
- You must preauthorize

Emergency Room

- The plan pays 80% after your \$25 copayment; you pay 20%
- You do not need to authorize the initial visit, but you must preauthorize any follow-up care with Deseret Mutual

Eye Exams

- Contracted provider: The plan pays 80% after your \$25 copayment; you pay 20%
- Non-contracted provider: The plan pays 50% after your \$25 copayment; you pay 50%
- One routine eye exam per person is eligible for benefits each plan year
- Eye exams for medical conditions, such as glaucoma, may be eligible for benefits more often. You must preauthorize

Food Supplements

- Contracted provider: The plan pays 80%; you pay 20%
- Non-contracted provider: The plan pays 50%; you pay 50%
- Food supplements for inborn errors of metabolism, such as phenylketonuria (PKU), are covered
- Food supplements must be consumed or administered under the supervision of a licensed physician

Home Health Care

- Contracted provider: The plan pays 80% after your \$25 copayment; you pay 20%
- Non-contracted provider: The plan pays 50% after your \$25 copayment; you pay 50%
- To be eligible for benefits, services must be performed by a licensed Registered Nurse or a Licensed Practical Nurse
- 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 eligible for benefits
- You must preauthorize

Immunizations for Children

- The plan pays 100%
- Immunizations will be provided for children younger than 6

Infertility

- Contracted provider: The plan pays 80%; you pay 20%
- Non-contracted provider: The plan pays 50%; you pay 50%
- In vitro fertilization is eligible for benefits for one time only. See [In Vitro Fertilization](#) on page 13.
- You must preauthorize

Injections (Allergy, Intramuscular, etc.)

- Contracted provider: The plan pays 80%; you pay 20%
- Non-contracted provider: The plan pays 50%; you pay 50%

Inpatient Hospital Services

- Contracted provider: The plan pays 80%; you pay 20%
- Non-contracted provider: The plan pays 50%; you pay 50%
- You pay a \$200 copayment per admission and \$50 for newborn infants
- When semi-private rooms are available, the plan does not pay for private rooms
- You must preauthorize. If you do not preauthorize your hospital stay, you will be charged an additional \$100 copayment
- For more information, please see [Maternity – Hospitalization](#) on page 14

Inpatient Physician Services

- Contracted provider: The plan pays 80%; you pay 20%
- Non-contracted provider: The plan pays 50%; you pay 50%
- You must preauthorize

In Vitro Fertilization

- Contracted provider: The plan pays 80%; you pay 20%
- Non-contracted provider: The plan pays 50%; you pay 50%
- In vitro fertilization is eligible for benefits for one time only
- You must have at least a five-year history of infertility associated with endometriosis, diethylstilbestrol (des), blockage or removal of fallopian tube, or abnormal male factors
- You must have exhausted other methods of covered fertility treatment
- The patient's spouse must be the sperm donor
- Procedures must be performed at medical facilities that conform to the American College of Obstetric and Gynecology guidelines for in vitro fertilization clinics, or to the American Fertility Society minimal standards for programs of in vitro fertilization
- You must preauthorize

Laboratory Services

- Contracted provider: The plan pays 80%; you pay 20%
- Non-contracted provider: The plan pays 50%; you pay 50%

Maternity

- Contracted provider: The plan pays 80%; you pay 20%
- Non-contracted provider: The plan pays 50%; you pay 50%
- To be eligible for benefits, you must maintain maternity coverage continuously from the date of conception to the date of delivery
- Non-student spouses enrolled in the non-maternity coverage option do not have coverage for normal maternity expenses. However, eligible expenses of more than \$4,000 that are incurred as a direct result of complications of pregnancy will be covered, subject to normal plan provisions
- The SHC provides pregnancy tests, but you will be referred to a contracted provider for other ongoing maternity care
- Remember, you will receive separate bills for the newborn baby's medical care. Newborn dependents will be covered for care and treatment of medically diagnosed congenital defects and birth abnormalities from the date of birth for 31 days. If you want to add your newborn child to your Student Health Plan coverage and receive plan benefits for the baby's expenses, **you must enroll the child within 60 days of the birth** (see [page 4](#)). You will be charged a premium retroactive to the date of the baby's birth

Maternity – Hospitalization

- Contracted provider: The plan pays 80%; you pay 20%
- Non-contracted provider: The plan pays 50%; you pay 50%
- You pay a \$200 copayment per admission (\$50 for newborn infants)
- When you deliver at a contracted hospital, services are provided at discounted rates
- You must preauthorize hospital stays (when medically necessary) of more than two days for a vaginal delivery or four days for a cesarean section delivery. If you do not preauthorize your extended hospital stay, additional days will be subject to medical review and you will be charged an additional \$100 copayment. For preauthorization, contact Deseret Mutual before your stay is extended
- When semi-private rooms are available, the plan will not pay for private rooms
- Some maternity-related expenses, such as expenses for miscarriage or false labor, are not considered in the contracted hospital rates. In such cases, the hospital will charge its regular fees and the plan's regular benefits and hospitalization copayments will apply to these charges

Maternity – Physician / Nurse-Midwife Services

- Contracted provider: The plan pays 80%; you pay 20%
- Non-contracted provider: The plan pays 50%; you pay 50%
- You pay a \$25 copayment per visit (maximum total copayment of \$150 for routine care)
- When you receive care from a contracted provider on Oahu, services are provided at discounted rates
- After you pay the appropriate copayments, the plan pays the balance of the contracted rate
- The contracted rate covers prenatal care and delivery provided by one physician throughout the term of the pregnancy
- If you are away from Oahu for part of the pregnancy, or if your care must be provided by more than one doctor, your bills will probably exceed the contracted rate. Therefore, your total copayment may be more. For more information, please contact Deseret Mutual
- Additional services, such as ultrasounds and amniocentesis, are billed separately and normal plan benefits and copayments apply to the additional charges. If pap smears or other services are recommended by your physician, remember to contact the SHC first for preauthorization. To be eligible for benefits, many of the tests must be provided at the SHC
- Other physicians involved in the medical care for you and your baby, such as anesthesiologists or pediatricians, will bill you separately. Regular plan benefits and copayments will apply to these charges

Medical Equipment (Durable)

- Durable medical equipment is a device that is durable, primarily serves a medical purpose, generally is not useful to people in the absence of illness, injury, or congenital defect, and is appropriate for use in the home. Please note, not all equipment that meets these requirements is eligible for benefits
- Contracted provider: The plan pays 80% after your \$25 copayment; you pay 20%
- Non-contracted provider: The plan pays 50% after your \$25 copayment; you pay 50%
- To be eligible for benefits, you must have a prescription from your physician
- You must preauthorize certain medical equipment. For information about equipment requiring preauthorization, please refer to the [table](#) below. If you do not, the purchase or rental of the equipment will be reviewed retrospectively (after the fact) to determine if it is eligible for coverage
- Time limitations apply to replacing some equipment
- You are responsible for expenses associated with the maintenance and upkeep of your medical equipment
- In some instances, if you purchase the equipment after you rent it, the rental price may be applied to the purchase price

Medical Equipment		
Must be preauthorized	Does not need to be preauthorized	Is not eligible for benefits
Bone growth stimulators Communication devices CPM machines Helmet therapy Hospital beds / mattresses Insulin pumps Light boxes for dermatological problems Lymphopresses Oxygen concentrators Respirators / ventilators Scooters Standers Tens units / EMS units ThAIRpy vests Wheelchairs	Apnea monitors (newborns only) Bilirubin lights Blood pressure kits Breast prosthetics (external) Canes Commodes Crutches Enteral infusion pumps / Kangaroo feeding pumps Gait trainers Glucometers Hoyer lifts Nebulizers / Pulmoaides Orthopedic braces Overhead trapeze Oxygen Pacemakers Reflux boards Side rails for beds Transfer boards Walkers	Air filtration systems Breast pumps Exercise equipment Eye glasses / contact lenses Hearing devices Humidifiers / dehumidifiers Interferential stimulators Knee braces used solely for sports Learning devices Lift chairs Modifications associated with: <ul style="list-style-type: none"> • Activities of daily living • Homes / structures • Vehicles Spa memberships Thermal therapy devices (cold / hot) Whirlpools

Medical Supplies

- Medical supplies are disposable, one-use-only medical items for immediate use. These include dressings and ace bandages
- Contracted provider: The plan pays 80%; you pay 20%
- Non-contracted provider: The plan pays 50%; you pay 50%
- To be eligible for benefits, you must have a prescription from your physician

Mental Health Therapy

- Contracted provider: The plan pays 80%; you pay 20%
- Non-contracted provider: The plan pays 50%; you pay 50%
- To be eligible for benefits, services must be provided by a physician, psychologist, clinical social worker, or advanced practice registered nurse
- The benefit covers up to 30 outpatient visits and 30 inpatient days per person per academic year
- If you can be discharged from an inpatient acute care setting to a less expensive alternative care setting (day treatment or partial day treatment) without compromising the quality of care, you may qualify for a maximum of 60 days per academic year. Residential treatment is not eligible for benefits
- Any prior inpatient days will be applied to your maximum 60 day alternative care benefit. One inpatient day is treated the same as two alternative care days
- Some mental health disorders, such as schizophrenia and bipolar disorder, might be approved for additional visits. Please call Deseret Mutual for more information
- This benefit covers treatment of autism
- You must preauthorize

Office Visits

- Contracted provider: The plan pays 80% after your \$25 copayment; you pay 20%
- Non-contracted provider: The plan pays 50% after your \$25 copayment; you pay 50%
- This benefit covers preventive care for children younger than 18
- You must preauthorize
- For office visits at the SHC, the plan pays 100% after your \$10 copayment

Pain Clinics

- Contracted provider: The plan pays 80%; you pay 20%
- Non-contracted provider: The plan pays 50%; you pay 50%
- The benefit is for either inpatient or outpatient care
- When semi-private rooms are available, the plan does not pay for private rooms
- Outpatient services have a five visit or \$1,500 benefit limit
- You must preauthorize

Physical Therapy – Outpatient

- Contracted provider: The plan pays 100% after your \$10 copayment
- Non-contracted provider: The plan pays 50% after your \$25 copayment; you pay 50%
- The plan covers up to 20 visits per person per academic year
- Inpatient visits do not count toward your annual outpatient visit limit
- You must preauthorize and obtain a referral from the SHC. If you do not preauthorize, you will be charged an additional \$100 copayment

Prescription Drugs

- Formulary drugs: For prescriptions purchased through the mail-service pharmacy, the plan pays 80%; you pay 20%. For prescriptions purchased at a Medco Health participating pharmacy, the plan pays 70%; you pay 30%
- Non-formulary drugs: The plan pays 50%; you pay 50%
- For certain classes of drugs, coverage is limited in the quantity of medication covered per prescription. This is in accordance with FDA and manufacturer guidelines
- You must preauthorize birth control medications for medical necessity
- Some items that can be prescribed but are not eligible for benefits include:
 - Contraceptive pills for birth control
 - Dietary or nutritional products, including special diets for medical problems
 - Propecia
 - Viagra
 - Vitamins, except prescribed prenatal vitamins and prescribed infant vitamins
 - Weight reduction aids
- Learn more about Medco Health and participating pharmacies at www.medcohealth.com or call 1-800-711-4542

Prosthetics

- This benefit includes prosthetics such as artificial arms or legs
- Contracted provider: The plan pays 80% after your \$25 copayment; you pay 20%
- Non-contracted provider: The plan pays 50% after your \$25 copayment; you pay 50%
- To be eligible for benefits, you must have a prescription from your physician
- You must preauthorize
- This benefit is limited to a new diagnosis requiring prosthetic. Replacements of old, less technical, or lost prosthetics are not eligible for benefits

Radiation Therapy

- Contracted provider: The plan pays 80%; you pay 20%
- Non-contracted provider: The plan pays 50%; you pay 50%
- You must preauthorize

Radiology Services (Mammograms, X-rays, CT Scans, MRIs, etc.)

- Contracted provider: The plan pays 80%; you pay 20%
- Non-contracted provider: The plan pays 50%; you pay 50%
- Routine mammograms are covered once every plan year. For women with a personal or family history of breast cancer, a mammogram is covered upon the recommendation of her physician
- You must preauthorize some services, like Magnetic Resonance Imaging (MRI)

Surgery – Inpatient Hospital Services

- Contracted provider: The plan pays 80% after your \$25 copayment; you pay 20%
- Non-contracted provider: The plan pays 50% after your \$25 copayment; you pay 50%
- You must preauthorize

Surgery – Outpatient Hospital Services

- Contracted provider: The plan pays 80% after your \$25 copayment; you pay 20%
- Non-contracted provider: The plan pays 50% after your \$25 copayment; you pay 50%
- You must preauthorize

Surgery – Physician Services

- Contracted provider: The plan pays 80% after your \$25 copayment; you pay 20%
- Non-contracted provider: The plan pays 50% after your \$25 copayment; you pay 50%
- You must preauthorize

Well Baby Care

- Contracted provider: The plan pays 80% after your \$25 copayment; you pay 20%
- Non-contracted provider: The plan pays 50% after your \$25 copayment; you pay 50%
- You must preauthorize
- Services are provided at the SHC for a \$10 copayment

Are there services the plan does not cover?

Yes. Please refer to [page 20](#) for a list of plan exclusions.

What is Deseret Mutual's Preferred Provider Network?

If you are away from Oahu while you are enrolled in the Student Health Plan, you may obtain care from any qualified, appropriately licensed medical provider. However, it is to your advantage to make sure the physicians and hospitals providing your care are part of Deseret Mutual's Preferred Provider Network. Your benefits will be higher and the providers will not bill you for fees that exceed Deseret Mutual's maximum allowable amounts.

For information about providers in your area, please call the appropriate telephone number. Be sure to identify yourself as a participant in a Deseret Mutual plan.

Remember, eligible expenses for services from contracted providers are covered at 80 percent, while eligible expenses for services from non-contracted providers are covered at 50 percent of maximum allowable charges (see [page 4](#)).

Hawaii: MDX (formerly, Queen's Health Care Plan Network)
1-808-293-3970

Idaho and Utah: Deseret Mutual Contracted Providers
1-800-777-3622 or www.dmba.com/nsc/medical/provpick.htm

All other states: First Health Medical Network
1-800-237-5702 or www.firsthealth.com (Login ID: DMB)

What should I do in an emergency?

Preauthorization is not required for emergency room visits. However, the costs for services in emergency rooms are considerably higher which could increase your out-of-pocket costs. If you are faced with a life-threatening emergency, you should seek immediate medical treatment from a qualified, accessible provider.

Life-threatening emergencies are those in connection with a sudden and unexpected onset of a condition requiring immediate medical or surgical care to safeguard the patient's life. This includes heart attack, severe bleeding, loss of consciousness, convulsions, or temperature of more than 104° Fahrenheit.

Other medical emergencies are those that are not life threatening, but the onset of symptoms is so sudden and severe that immediate medical or surgical treatment is required to prevent serious impairment of bodily functions.

In the case of an emergency that is not life threatening, contact the SHC immediately. You will be instructed to go either to the SHC or to another emergency care provider for treatment.

If such an emergency occurs when the SHC is closed, call the after-hours telephone number. If you are directed to seek care from another qualified, accessible provider, contact the SHC within two working days to coordinate care.

What about follow-up to emergency care?

Contact the SHC before you receive any follow-up care. Most follow-up care can be provided at the SHC. If you need to receive follow-up care outside the SHC, you must preauthorize with Deseret Mutual before you receive the care.

Remember, if you receive follow-up care outside the SHC without preauthorization from Deseret Mutual, you must pay a \$100 copayment per service.

How do I submit a claim for payment?

To receive plan benefits for services provided outside the SHC, submit an itemized bill and claim form, along with the preauthorization, to:

Deseret Mutual
BYU-Hawaii #1972
55-220 Kulanui Street
Laie, Hawaii 96762

To be eligible for coverage, claims must be submitted within 15 months of the date of service. You do not need to submit claims for services received at the SHC.

Large Claims Coverage

BYU-Hawaii provides Large Claims Coverage for all full-time students and their eligible dependents. This policy is separate from the Student Health Plan. You must be enrolled as a full-time student at BYU-Hawaii, but you do not need to be enrolled in the Student Health Plan to be covered by BYU-Hawaii's Large Claims Coverage Plan.

Large Claims Coverage is secondary to any other primary insurance plans, group or individual policies. This plan is designed to provide benefits if you incur large medical expenses beyond the limits of your primary coverage.

Before you can be eligible for benefits, you must document annual charges of \$37,500. All eligible expenses related to the original illness or accident that exceed \$37,500 and are not covered by a group plan or other primary insurance will be covered at 100 percent to a maximum of \$90,000 per person per academic year.

If the accident or medical condition causes you to drop out of school, your coverage will be extended for six months beyond the last semester or term in which you were enrolled.

Contact the Student Insurance Office if you need assistance from the Large Claims Coverage Plan. For more information about the plan's coverage and limitations, see the Large Claims Coverage Agreement, available for review at Deseret Mutual's Hawaii office.

Repatriation of Remains

If a covered accident or illness causes the death of an insured student while he or she is in a foreign country (that is, the student is not a citizen of the country), the plan will pay expenses for returning the body to the country of citizenship up to a maximum benefit of \$7,500. To be eligible for coverage, expenses must be approved in advance. Please call Deseret Mutual at 1-800-777-3622 for more information.

Exclusions

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

Alternative Care

- 1.1 Holistic, homeopathic, ecological, or environmental treatment
- 1.2 Acupuncture
- 1.3 Vertebral column rehabilitation (chiropractic care) or massage therapy

Congenital Anomalies

- 2.1 Care, treatment, or operations provided outside the SHC in connection with congenital anomalies when such services are performed to restore normal body form or appearance, the conditions are not immediately life threatening, and/or the timing is subject to the choice or decision of the patient and physician. This exclusion does not apply to care, treatment, or operations to treat congenital anomalies in children for whom coverage by the plan has been maintained since birth

Convenience Services

- 3.1 Care, treatment, supplies, or other services incurred primarily for convenience, contentment, or other non-therapeutic purposes

Custodial Care

- 4.1 Hospice care, custodial care, education, training, or rest cures

Dental Care

- 5.1 Dental treatment, except that made necessary by accidental injury to sound natural teeth, as provided for by the plan

Exclusions (Continued)

Diagnostic & Experimental Services

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

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

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

Educational Programs

7.1 Educational programs (except for diabetes education) provided outside the SHC (PMS clinics, etc.)

Fertility / Family Planning / Home Delivery

8.1 Reproductive organ prostheses

8.2 Care, treatment, or operations provided in connection with sexual dysfunction

8.3 Abortions, except in cases when the life of the mother would be seriously endangered if the fetus were carried to term

8.4 Family planning, including contraception, birth control devices, surgery, and/or drugs

8.5 Planned home delivery for childbirth

8.6 Services related to the evaluation and treatment of the cause(s) of multiple miscarriages (the miscarriage itself is covered)

Government / War

9.1 Services furnished by a hospital or facility owned or operated by the United States Government or any agency thereof; any charges for services, treatments, or supplies furnished by or for the United States Government or any agency thereof

9.2 Services covered, or which could have been covered, by any governmental plans (including, but not limited to, Medicare or Medicaid)

9.3 Conditions caused by or resulting from war or act of war or service in the military forces of any country at war, declared or undeclared. War includes hostilities conducted by force or arms by one country against another country, or between countries or factions within a country, either with or without a formal declaration of war

Hearing

10.1 The purchase or fitting of hearing devices

Legal Exclusions

11.1 Services provided before coverage begins and services after coverage ends

11.2 Accidents sustained as a result of play, practice, or participation in intercollegiate sports, the ROTC program, professional contests, or vehicular contests

11.3 Care, treatment, diagnostic procedures, or any other expenses when it has been determined by Deseret Mutual that brain death has occurred

11.4 Services incurred in connection with injury arising from participation in or attempt at committing an assault or felony, participation in illegal acts of violence, or services provided as a result of a court order, or for other legal proceedings

11.5 Services for which the covered person has no legal obligation to pay

11.6 Services that a third party or the liability insurance of a third party or the uninsured motorist insurance pays or is obligated to pay

Exclusions (Continued)

Legal Exclusions (Continued)

- 11.7 Conditions resulting from catastrophic events defined as an earthquake, fire, terrorist attack, any other accidental occurrence or series of one event, or a group of related events within seven days or less resulting in the death or serious injury of 20 or more covered students
- 11.8 Complications resulting from excluded services
- 11.9 Services not specified as covered
- 11.10 Care, treatment, or operations incurred after coverage ends

Medical Equipment

- 12.1 Breast pumps, knee braces used solely for sports, and learning devices
- 12.2 Multipurpose equipment or facilities, such as those listed in the Medical Equipment chart on page 15
- 12.3 Modifications to homes, other structures, or motor vehicles to accommodate activities of daily living

Medical Necessity / Cosmetic

- 13.1 Care, treatment, or operations that are not clearly a medical necessity
- 13.2 Wart removal, treatment of toenails, corns, calluses, or bunions provided outside the SHC
- 13.3 Care, treatment, or operations that are performed primarily for cosmetic purposes (non-suspicious mole removal, breast reduction, normal or abnormal hair loss, etc.), except for expenses incurred as a result of injury suffered while covered by this plan
- 13.4 Care, treatment, diagnostic procedures, or other expenses for an abdominoplasty, lipectomy, panniculectomy, skin furrow removal, or diastasis rectus repair
- 13.5 Special formulas, food supplements, or special diets except in cases of inborn metabolic disorders
- 13.6 Cardiopulmonary fitness training or conditioning, either as a preventive or therapeutic measure

Mental Health / Counseling / Chemical Dependency

- 14.1 Marriage and family counseling provided outside the SHC
- 14.2 Care or treatment provided outside the SHC in connection with anorexia, bulimia, or other eating disorders

Miscellaneous

- 15.1 Physical exams for the purpose of obtaining insurance, employment, or government licensing
- 15.2 Care, treatment, diagnostic procedures, equipment, or any other services for sleep disorders, chronic fatigue, or fibromyalgia provided outside the SHC
- 15.3 Aviation-related accidents (including but not limited to parachuting, hang gliding, or ballooning events), other than to passengers on scheduled commercial airlines
- 15.4 Services of any practitioner of the healing arts who ordinarily resides in the same household with you or your dependents, or has legal responsibility for financial support and maintenance of you or your dependents

Obesity

- 16.1 Care, treatment, or operations provided outside the SHC in connection with obesity or weight loss (including gastric bypass surgery)

Other Insurance / Workers' Compensation

- 17.1 Services covered or that could have been covered by applicable workers' compensation statutes
- 17.2 Services or materials covered or that could have been covered by insurance required or provided by any statute had the participant complied with the statutory requirements, including but not limited to no-fault insurance

Pain Control

- 18.1 Services provided outside the SHC for chronic pain management

Exclusions (Continued)

Prescription Drugs, Specialty Pharmacy Medications, Formulas, & Supplements

- 19.1 Preventive medicine or vaccines, including immunizations except for children younger than 6
- 19.2 Special formulas, food supplements, or special diets except in cases of inborn metabolic disorders
- 19.3 Specialty pharmacy medications for conditions including but not limited to: hemophilia (i.e., Factor Products, Benefix); multiple sclerosis (Avonex or Copaxone); HIV / AIDS; hepatitis C (Peg-Intron); oral or self-administered chemotherapy agents (Gleevec, Procrit, or Epogen); infertility (Clomid); Crohn's disease (Remicade); rheumatoid arthritis (Raptiva or Enbrel); growth hormone deficiencies (Humatrope or Nutropin); asthma (Xolair); or diabetes (Byetta)

Routine Services

- 20.1 Routine physical exams for adults 18 years and older

Speech Therapy

- 21.1 Speech therapy and evaluation

TMJ

- 22.1 Services and materials in connection with disturbances of the temporomandibular joint (TMJ)
- 22.2 Jaw surgery (osteotomy)

Testing

- 23.1 Diagnostic services that are not related to an injury or illness, unless otherwise provided for by the plan

Transplants

- 24.1 Care, treatment, diagnostic procedures, or operations in relation to transplants (donor or artificial)

Vision

- 25.1 Eyeglasses and contact lenses or the replacement or prescription thereof
- 25.2 Care, treatment, diagnostic procedures, or other expenses for elective surgeries to correct vision

Legal Notice

This handbook provides you with an explanation of your benefits under the BYU-Hawaii Student Health Plan and constitutes a legal contract between you and Deseret Mutual.

Claims Review Procedures

If you have questions, concerns, or complaints, please bring them to our attention. This includes complaints about the SHC, contracted and non-contracted physicians and facilities, administrative procedures, claims payments, or preauthorization procedures.

If you have concerns about the SHC, its staff, or services you receive there, please call the SHC director at 1-808-293-3510 or 293-3487, or visit or write to 55-220 Kulanui St. #1916, Laie, Hawaii 96762.

If you have concerns about services you received outside the SHC, please contact the Deseret Mutual Hawaii Manager at 1-808-293-3970.

To file a complaint about claims for services received outside the SHC, or concerning administrative or preauthorization procedures, please follow these steps:

- Submit a written statement to Deseret Mutual, Attention: Student Plan Claims Management. Please detail the nature of your complaint. Deseret Mutual will begin a review within 10 working days. After this review, you can expect a written response to the complaint.
- If your complaint still remains unresolved, you may submit it to: Student Health Plans Claims Review Committee, P.O. Box 45530, Salt Lake City, Utah 84145.

The Committee meets on a monthly basis and includes representatives of the student body, physicians, legal counsel, and consulting professional personnel from the SHC and Deseret Mutual.

All appeals must be received within 15 months of the original date of benefit determination.

Please refer to the table below that shows when you must submit appeal requests, as well as when you can expect written responses to those requests.

	Urgent-care Health Claims	Pre-service Health Claims	Post-service Health Claims
Deseret Mutual must provide notice of the initial claim denial by . . .	72 hours after receiving the claim if it was properly completed. 48 hours: (1) after receiving completed claim or (2) after the 48-hour claimant deadline, whichever is earlier.	15 days after receiving the initial claim. 30 days after receiving the claim if we need more information and we provide an extension notice during the initial 15-day period.	30 days after receiving the initial claim. 45 days after receiving the claim if we need more information and we provide an extension notice during the initial 30-day period.
Deseret Mutual must provide an incomplete claim notice and request additional information by . . .	24 hours after receiving claim	5 days after receiving claim	30 days after receiving claim, extended 15 days from the date we receive the required information
Claimant must complete claim by . . .	Not applicable	45 days after receiving notice to provide information	45 days after receiving notice to provide information
Claimant must appeal decision by . . .	15 months after receiving the claim denial	15 months after receiving the claim denial	15 months after receiving the claim denial
Deseret Mutual must provide a notice of decision of appeal by . . .	72 hours after request for review (either verbal or written)	30 days. Two levels of review are available: (1) CMRC will respond within 15 days of written request. (2) CRC will respond within 15 days of request (either verbal or written)	60 days. Two levels of review are available: (1) CMRC will respond within 30 days of written request. (2) CRC will respond within 30 days of request (either verbal or written)

Request for Review by Insurance Commissioner

You may request a review by a panel selected by the Hawaii Insurance Commissioner. To do this, submit your review request within 60 days of the date of our decision to the Insurance Commissioner at:

Hawaii Insurance Division
Attention: Health Insurance Branch—External Appeals
335 Merchant Street, Room 213
Honolulu, HI 96813
Telephone: 1-808-586-2804

If the Commissioner accepts your review request, a hearing will be conducted within 60 days. A decision will be issued within 30 days of the hearing. You may request an expedited review if following the above time frames may:

- Seriously jeopardize your life or health,
- Seriously jeopardize your ability to gain maximum functioning, or
- Subject you to severe pain that can't be managed without the care or treatment that is the subject of the appeal

The expedited appeal will be determined no later than 72 hours after the Commissioner receives your request.

Coordination of Benefits

The Student Health Plans (the basic BYU-Hawaii Student Health Plan, Away-from-Campus Coverage, Extended Coverage, and Large Claims Coverage) are usually primary to all other insurance coverage.

Therefore, if you are covered as a dependent on another group insurance plan, you should submit your claims to the Student Health Plan first and then to the other plan for payment.

Subrogation

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

- First
- From any recovery from a claim against a third party, the third party's liability insurance carrier, or your uninsured and/or underinsured motorist insurance carrier
- Whether the recovery is obtained by settlement, judgment, or from any other source
- Regardless of how the settlement is allocated by the third party or insurance carrier

Your acceptance of Deseret Mutual benefits for the injury constitutes subrogation. You must provide any information Deseret Mutual requests for subrogation purposes. If you fail to do so, you will be responsible for reimbursing all the costs and expenses paid by Deseret Mutual for the injury.

Notification of Benefit Changes

Deseret Mutual reserves the right to amend or terminate the plan at any time. If benefits change, we will notify you at least 30 days before the effective date of change.

For the most up-to-date listing of plan benefits and exclusions, refer to the Student Health Plan handbook Web site at www.dmba.com/nsc/student/handbooks.htm.

Notification of Discretionary Authority

DMIC and its administrators have full discretionary authority to interpret the plan and to determine benefit eligibility. Also, DMIC has the sole right to construe plan terms except where a specific statute applies. All DMIC decisions relating to plan terms or eligibility for benefits are binding and conclusive.

Fraud Policy Statement

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

Important Dates

FALL 2007

- Aug. 22 Insurance coverage begins / IWES check-in
- Aug. 29 Classes begin / fall semester premiums due
- Sep. 14 Last day for students to submit 2007-2008 insurance enrollment or waiver and certification of other coverage
- Dec. 29 Fall semester coverage ends

WINTER 2008

- Dec. 30 Insurance coverage begins / IWES check-in
- Jan. 9 Classes begin / winter semester premiums due
- Jan. 25 Last day for new students to submit 2007-2008 insurance enrollment or waiver and certification of other coverage
- Apr. 19 Winter semester coverage ends

SPRING 2008

- Apr. 20 Insurance coverage begins / IWES check-in
- Apr. 30 Classes begin / spring term premiums due
- May 10 Last day for new students to submit 2007-2008 insurance enrollment or waiver and certification of other coverage
- Jun. 21 Spring term coverage ends / commencement

SUMMER 2008

- Jun. 22 Insurance coverage begins / IWES check-in
- Jun. 25 Classes begin / summer semester premiums due
- Jul. 5 Last day for students to submit 2007-2008 insurance enrollment or waiver and certification of other coverage
- Aug. 21 Summer term ends

Definitions

Accident

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

Acute

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

Coinsurance

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

Contracted Facilities

Hospitals, clinics, labs, and other health-care facilities that have contracted with Deseret Mutual to provide services to participants.

Contracted Providers

Physicians, specialists, and other providers of health-care services who have contracted with Deseret Mutual to provide services to participants.

Copayment

The initial dollar amount you pay for an eligible medical expense at the time services are rendered.

Custodial Care

Maintaining a patient beyond the acute phase of injury or illness. Custodial care includes room, meals, bed, or skilled medical care in any hospital or extended care facility, or at home to help the patient with feeding, bowel and bladder care, respiratory support, physical therapy, administration of medications, bathing, dressing, ambulation, and so on. The patient's impairment, regardless of the severity, must require such support to continue for more than two weeks after establishing a pattern of this type of care.

Day Treatment Program for Mental Illness

An outpatient program that is staffed and managed by licensed, clinical professionals providing mental illness treatment for a portion of the day, typically eight hours.

Elective Surgery

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

Eligibility Date

The date you become eligible for benefits.

Eligible Charges / Expenses

Expenses incurred by you or a dependent for treatment of injury or illness and that are:

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

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

Emergency Care

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

Extended Care Facility

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

Formulary Medications

A preferred list of medications that have been reviewed by an independent pharmacy and therapeutics committee for safety and efficacy. Formulary medications are covered at a higher benefit.

Illness

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

Inpatient Hospital for Mental Illness

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

Maximum Allowable Charge (Limit)

The maximum dollar amount Deseret Mutual will pay for a defined procedure.

Medical Equipment

A prosthesis, appliance, or device that is primarily and customarily used to serve a medical purpose and generally is not useful to a person in the absence of injury, illness, or congenital defect.

Medical Supply

Medical items that are for immediate use, are disposable, and are not reusable.

Medical Treatment

Therapeutic measure(s), including consultations, undertaken by or under the direction of a physician in connection with an injury or illness.

Non-contracted Facilities

Hospitals, labs, and other health-care facilities that have not contracted with Deseret Mutual to provide services to participants.

Physician

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

Preauthorization

A process of advance notification that is required for a number of benefits. When you preauthorize services with Deseret Mutual, you receive guidelines about what services are eligible for benefits before you commit to the costs.

Residential Treatment Center for Mental Illness

A facility that is licensed by the state to provide residential treatment of mental illness that has licensed, clinical professionals providing specific treatment for either mental illness or chemical dependency.

Surgical Center

Any licensed public or private establishment:

- With an organized medical staff of physicians.
- With permanent facilities equipped and operated primarily for the purpose of performing surgical procedures.
- With continuous physician services whenever a patient is in the facility.
- That does not provide services or other accommodations for patients to stay overnight.

INDEX

Accident	26
Acute	26
After-hours emergencies	19
Alcohol dependency	10
Allergy services	10, 12
Alternative care	20
Ambulance	10
Anesthesia	10
Away-from-Campus Coverage	6
Beginning of coverage	7
Benefit changes	25
Chemical dependency	10
Chemotherapy	11
Claims, payment of	19
Claims, review procedures	23
Coinsurance	27
Contact information (phone, email, addresses)	ii
Contracted facilities	27
Contracted providers	27
Coordination of benefits	25
Copayment	27
Hospitalization	3
Maternity care	13, 14
Services at the SHC	3
Services outside the SHC	3
Counseling	22
Cosmetic	22
Coverage options	6
Coverage, periods of	7
Custodial care	27
Dates and deadlines	26
Day treatment program	27
Definitions	26
Dental accident benefit	11
Dental, discounted	9
Dependents	4
Diabetes education	11
Diabetic supplies	11
Dialysis	11
Discretionary authority	25

Deseret Mutual	ii
Elective surgery	27
Eligibility	4
Eligibility date	27
Eligible charges	27
Emergency	11, 28
Ending of coverage	7
Enrollment	4
Away-from-Campus	6
Changes	4
Extended	6
Exclusions	20
Explanation of benefits	3
Extended care facility	28
Extended coverage	6
Eye exams	11
Food supplements	12
Formulary medications	28
Graduation or change of status	5
Home health care	12
Hospital	
Emergency	11
Inpatient	12, 28
Maternity	14
Illness	28
Immunizations	12
Important keys to remember	2
Infertility	12
Injections	12
In vitro fertilization	13
Laboratory services	13
Large claims coverage	20
Leaving BYU	5
Maternity	13
Hospitalization	14
Physician services	14
Maximum allowable charges	3, 28
Medical equipment	15, 28
Medical supplies	16, 28
Medical treatment	28
Mental health	16, 28

Missionary service	5
Non-contracted facilities	28
Office visits	16
Pain clinics	16
Pediatrics	18
Pharmacy	17 , 23
Physical therapy, outpatient	17
Physician	28
Physician services	
Inpatient	13
Maternity	14
Office visits	16
SHC	9
Surgery	18
Plan changes	25
Preauthorization	29
Preferred Provider Network	18
Premiums	8 , 9
Prescription drugs	17
Prosthetics	17
Radiation therapy	17
Radiology services	18
Repatriation	20
Residential treatment center	29
Services at other university health centers	8
Student Health Center (SHC)	9
Copayments	3
Hours	9
Services	9
Subrogation	25
Surgery	
Inpatient	18
Outpatient	18
Physician services	18
Surgical center	29
Telephone numbers	ii
Well baby care	18
Who to contact	ii
X-rays	18



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