

Deseret Mutual Benefit Administrators

BRIGHAM YOUNG UNIVERSITY – HAWAII

Student Health Plan 2008-2009

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.	
Preauthorization	You must preauthorize all services outside the SHC, except emergency room visits. Before you receive the medical care, you or your provider must call Deseret Mutual at 1-808-675-3972 to obtain your preauthorization number (see page 7).	
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 17).	
Explanation of Covered Expenses	Plan payments are subject to maximum allowable charges, determined by Deseret Mutual (see page 25).	
	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 eligible DME (see page 12)	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 11 to 12)	<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 8, 9 and 15)	80% of allowable charges after copayment	50% of allowable charges after copayment
Physical Therapy (See page 14)	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

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	1-808-675-3512
Fax	1-808-675-3657
Deseret Mutual	1-808-675-3970
Enrollment, Premium, & Coverage Information	1-808-675-3970
	1-808-675-3512
Deseret Mutual Preauthorization	1-808-675-3972
SHC Appointment Scheduling & Referrals.	1-808-675-3510
SHC After-hours Emergencies (On-call Nurse)	1-808-675-3911

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:

<https://www.dmba.com/sc/dmba/email.aspx>

Deseret Mutual's Preferred Provider Network

Hawaii: MDX (formerly, Queen's Health Care Plan Network)
1-808-675-3970

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

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.aspx

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To All Students

Welcome to the BYU-Hawaii Student Health Plan! Medical care in Hawaii is expensive and unique. It's important that you're covered by a qualified insurance plan while attending the University. For this reason, we've asked Deseret Mutual to provide an affordable comprehensive health plan that meets all state requirements.

This plan is underwritten by Deseret Mutual Insurance Company (DMIC) and administered by Deseret Mutual Benefit Administrators (Deseret Mutual), based in Salt Lake City, Utah. For your convenience, Deseret Mutual has a Hawaii office to serve you locally.

Many providers in Hawaii don't accept foreign or out-of-state insurance policies. Unexpected health costs can happen at any time to anyone, creating a financial burden for you, your family, and the community. **Therefore, the University requires all foreign students and their dependents to enroll in the BYU-Hawaii Student Health Plan for the duration of their university education, including summers or other short breaks from school.** Domestic students are strongly encouraged to enroll in the student Health Plan, but may waive this requirement if they're currently covered by a parent employee plan that:

- Provides a minimum of 80% coverage for all services (office visits, physician services, hospitalization, and ancillary care)
- Has an annual deductible of no more than \$500
- Has an annual limit of no less than \$25,000
- Includes medical care and treatment in Hawaii

All students enrolled for 9 or more credit hours during fall and winter semesters and 4.5 credit hours during each term will automatically be enrolled and charged for the Student Health Plan. Students who meet all of the above requirements and wish to waive coverage must complete the waiver and verification forms by the insurance deadline dates.

The Student Health Plan offers a wide range of basic medical coverage as described in the pages that follow. It's your responsibility to become familiar with your plan — all of its provisions, guidelines, and exclusions. We can't make exceptions to the plan's contractual provisions.

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. For information about what to do in an emergency, please see [page 6](#).
- Deseret Mutual will send your insurance card with your policy number about four weeks after they receive your enrollment. If you need medical care outside of the SHC before your card arrives, please contact Deseret Mutual for your policy information.
- To receive the highest benefit from your plan, you or your provider must contact Deseret Mutual to preauthorize before you receive services outside of the SHC. To obtain a preauthorization number, call 675-3972.
- Always receive care from providers who are contracted through Deseret Mutual's Preferred Provider Network. If you use non-contracted providers, your benefits will be lower. For information on the Preferred Provider Network, see [page 16](#).
- 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. To see which services are not covered, please read the [exclusions](#) beginning on page 17 carefully.
 - 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.

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. 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.

If you aren't enrolled 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 one or more semesters, you may enroll in Extended Coverage (see pages 4 to 5).

How are medical services paid?

When you receive care outside of the SHC, you pay a **copayment** and a **coinsurance** amount. After your copayment, the amount covered by the plan is your **plan benefit**, and the balance owing is your coinsurance amount, which will be billed to you by the provider.

Deseret Mutual will send you an explanation of benefits (EOB) by mail. This EOB statement will itemize how your bill was paid.

- 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. Health-care providers contracted with Deseret Mutual agree not to bill you for more than the maximum allowable amount. (For information about contracted providers, see [page 16](#)).
- 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 is 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

Amount Paid By the Student Health Plan and Your Coinsurance

	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%

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

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 17](#) about BYU-Hawaii's Large Claims Coverage.

Who is eligible to enroll?

Students: All full-time students are automatically enrolled in the Student Health Plan.

- Domestic students who have medical coverage that meets all insurance requirements may waive coverage in the Student Health Plan if they complete a waiver form as outlined in the handbook
- Foreign students and their eligible dependents are required to be enrolled in the Student Health Plan

Eligible dependents are defined as:

- 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.

When may I enroll?

You are automatically enrolled in the Student Health Plan 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 and assessed the appropriate premium unless you drop below full-time status or personally notify the Student Insurance Office.

Students with dependent coverage must go to the Student Insurance Office to enroll their dependents.

Verification and waiver forms must be submitted to the Student Insurance Office by the [deadlines](#) listed beginning on page 22.

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.

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 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 with medically diagnosed congenital defects and birth abnormalities will be covered for care and treatment from the date of birth for 31 days. To receive this coverage, you must add the newborn to your Student Health Plan policy (including Extended Coverage Plans).

- Adopted 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 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 and provide proof of the lost 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 22.

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 Student Health Plan during that semester/term unless you submit a waiver as proof of other coverage.

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 Student Health Plan during that semester/term.

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 4.

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.

You may add newly acquired dependents to your coverage only as outlined on [pages 3 and 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.

Extended Coverage plans are not eligible for Large Claims Coverage (see [page 17](#)).

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. 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 16](#)). **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 in Extended Coverage, contact the Hawaii campus Deseret Mutual office by the end of your last semester or term.

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

	Graduation or Loss of Continuing Student Status	Loss of Eligibility for Dependent	Move to Other Available Insurance
Regular On-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.		

day of classes. This coverage will be effective for up to seven days before you are due to report for classes or orientation.

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.

For the exact dates that coverage begins and ends for the 2008-2009 academic year, please see the calendar beginning on page 22.

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

	You and Your Current Dependents	New Dependent (Marriage)	Newborn Dependent (Natural or Adopted)	Adopted Dependent (Non-newborn)
Regular On-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.			

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 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 8 to 16](#) for coverage amounts. You will not need preauthorization.

	Regular On-Campus Coverage	Extended Coverage
Single Student Only	\$236/semester \$118/term	\$135/month
Married Student Only	\$296/semester \$148/term	\$162/month
Single Student with One or More Dependents	\$812/semester \$406/term	\$288/month
Married Student with One or More Dependents	\$1,216/semester \$608/term	\$590/month

What are the Student Health Plan premiums?

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 22.

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 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.

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 are:

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

The SHC is closed every weekend, 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 675-3911.

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

Services from another provider to be eligible for maximum plan benefits must be preauthorized by Deseret Mutual before you receive medical care. You or your provider must call Deseret Mutual at 675-3972.

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 8 to 16](#) 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% after your \$25 copayment (for outpatient services); 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

- The plan pays 80% after your \$25 copayment; you pay 20%
- 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

- The plan pays 80%; you pay 20%

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 \$50 copayment; you pay 20%
- You do not need to authorize the initial visit, but you must preauthorize any outside 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 with no preauthorization
- Eye exams for medical conditions, such as glaucoma, may be eligible for benefits more often, but 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

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% 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 11.
- 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 11

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% after your \$25 copayment; 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 infertility 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**
- The SHC provides pregnancy tests, but you will be referred to a contracted provider for other ongoing maternity care
- You will receive separate bills for the newborn baby's medical care. 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 [pages 3 to 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)
 - 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)
- 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
- 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. 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](#) on page 13. 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

Medical Equipment		
Must be preauthorized	Does not need to be preauthorized	Is not eligible for benefits
Bone growth stimulators Communication devices CPM machines Gait trainers Helmet therapy Hospital beds / mattresses Insulin pumps Intermittent limb compression device 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 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 includes two evaluations per academic year. A \$25 copayment is applicable.
- 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. Each visit is subject to the contracted and non-contracted rates after your \$25 copayment.
- 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
- If you don't use a contracted provider, 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.)

- The plan pays 80% after your \$25 copayment; you pay 20%
- 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 MRI, PET, SPECT scans

Surgery – Inpatient Hospital Services

- Contracted provider: The plan pays 80%; 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 provided at the SHC have a \$10 copayment

Are there services the plan does not cover?

Yes. For a list of plan exclusions, please refer to [page 17](#).

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 3](#)).

Hawaii: MDX (formerly, Queen's Health Care Plan Network)
1-808-675-3970 or 675-3972

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

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 outside 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?

Most providers in Hawaii will submit your claim to Deseret Mutual directly. If you pay for services, please bring your receipts to the Hawaii Deseret Mutual office.

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. Extended Coverage plans are not eligible for Large Claims Coverage.

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 or academic year 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

Exclusions (Continued)

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

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 of rape or incest or 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.

Exclusions (Continued)

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 participation in 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
- 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 13
- 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, 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, breast reduction, 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 (meaning reimbursement for gym, health, or fitness club memberships or fees), 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 Care, treatment, diagnostic procedures, equipment, or any other services for sleep disorders, chronic fatigue, or fibromyalgia provided outside the SHC
- 15.2 Deseret Mutual excludes sex change operations and all associated procedures and services (medical, psychological, pharmaceutical, surgical, etc.) from benefits in all medical plans
- 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

Exclusions (Continued)

Obesity

- 16.1 Care, treatment, or operations provided outside the SHC in connection with obesity or weight loss (including bariatric 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

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); diabetes (Byetta); or RSV (Synagis)

Routine Services

- 20.1 Routine physical exams for adults 18 years and older

Speech Therapy

- 21.1 Speech therapy and evaluation

TMJ Dysfunction

- 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 1-808-675-3510 or 675-3487, 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 1-808-675-3970.

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

- Come to the Hawaii Deseret Mutual office to discuss your complaint
- If your complaint is not resolved, prepare a written statement explaining the nature of your complaint and request a formal review by the Student Health Plan committee. This committee meets on a monthly basis and is comprised of the Medical Director, the Vice President of Administrative Services, and professional personnel from BYU-Hawaii and Deseret Mutual.
- 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.

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, 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.aspx.

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 SEMESTER 2008

- Aug. 17 Insurance coverage begins / IWES check-in
- Aug. 27 Classes begin / fall semester premiums due
- Sep. 4 Last day for students to submit 2008-2009 insurance enrollment or waiver and certification of other coverage
- Dec. 27 Fall semester coverage ends

WINTER SEMESTER 2009

- Dec. 28 Insurance coverage begins / IWES check-in
- Jan. 7 Classes begin / winter semester premiums due
- Jan. 10 Last day for new students to submit 2008-2009 insurance enrollment or waiver and certification of other coverage
- Apr. 11 Winter semester coverage ends

SPRING TERM 2009

- Apr. 12 Insurance coverage begins / IWES check-in
- Apr. 20 Classes begin / spring term premiums due
- Apr. 23 Last day for new students to submit 2008-2009 insurance enrollment or waiver and certification of other coverage
- Jun. 3 Spring term coverage ends / commencement

SUMMER TERM 2009

- Jun. 4 Insurance coverage begins / IWES check-in
- Jun. 8 Classes begin / summer term premiums due
- Jun. 11 Last day for students to submit 2008-2009 insurance enrollment or waiver and certification of other coverage
- Jul. 18 Summer term ends

FIRST TERM 2009

- Jul. 19 Classes begin / first term premiums due

Jul. 30	Last day for students to submit 2008-2009 insurance enrollment or waiver and certification of other coverage
Sep. 9	First 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.

Continuing Student

A BYU-Hawaii student who is enrolled at least 3/4-time for the current semester or term.

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.

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