

TEMPORARY BENEFITS RELATED TO COVID-19

Effective March 18, 2020 to January 21, 2021

COVID-19 EVALUATION

- Your Student Health Plan covers 100% of the maximum allowable amount for COVID-19 evaluation (office visit, urgent care, ER visit).
- No preauthorization is required.
- The annual deductible does not apply to this service.

COVID-19 TESTING

- Your Student Health Plan covers 100% of the maximum allowable amount for COVID-19 testing, including lab testing.
- No preauthorization is required.
- The annual deductible does not apply to this service.

MEDICAL OFFICE VISITS

- Your Student Health Plan covers medical office visits performed via telehealth.
- Standard Student Health Plan benefits apply.
- Temporary coverage applies only to scheduled medical office visits (CPTs 99201-99215) performed via telehealth due to COVID-19 related office closures. Telehealth services performed via “convenient care” or other typically app-based platforms remain excluded from SHP coverage.

MENTAL & BEHAVIORAL HEALTH COUNSELING VISITS

- Your Student Health Plan covers mental and behavioral health counseling visits performed via telehealth.
- Standard Student Health Plan benefits apply.

Effective April 10, 2020 to January 21, 2021

COVID-19 SEROLOGIC TESTING

- Your Student Health Plan covers 100% of the maximum allowable amount for serologic testing.
- No preauthorization is required.
- The annual deductible does not apply to this service.

BRIGHAM YOUNG UNIVERSITY-IDAHO

STUDENT HEALTH PLAN

2020-2021



Formally Registered as the Brigham Young University-Idaho Student Health Plan Trust

SHPBYUID.08/20

BRIGHAM YOUNG UNIVERSITY-IDAHO STUDENT HEALTH PLAN 2020-2021

NOTICE TO PLAN PARTICIPANTS

The BYU-Idaho Student Health Plan is a self-funded plan and not insurance. As such, it does not participate in the Idaho life and health guaranty association.

Deseret Mutual Insurance Company (“Deseret Mutual”) administers this plan, but does not insure it. The plan is self-funded through student contributions

STUDENT HEALTH PLAN AND NEW FEDERAL REQUIREMENTS

The Affordable Care Act (ACA), also known as Obamacare, requires most Americans to have health insurance that meets a government standard known as Minimum Essential Coverage (MEC) to avoid a tax penalty. The BYU-Idaho Student Health Plan is a non-MEC health plan and students should not rely solely on the Student Health Plan to avoid the tax penalty for not having MEC. If your only health coverage is the BYU-Idaho Student Health Plan, then you (or your parents, if you are a claimed tax dependent) may be subject to a tax penalty on federal income tax returns for the months you do not have MEC.

BYU-Idaho requires all matriculated students to have full medical health coverage while attending the university. For information about the requirement, including accepted coverage that allows you to waive enrollment in the Student Health Plan, see www.byui.edu/health-center/forms.

We understand there has been confusion due to the changes in federal law referred to as the Affordable Care Act and the impact of the Tax Cuts and Jobs Act of 2017 on its coverage requirements. We encourage you to consult with your parents and or a professional tax advisor for counsel. You can also find information at the following link:

<https://www.healthcare.gov/fees-exemptions/exemptions-from-the-fee/>

We encourage you to carefully review the terms of any plan, including deductible requirements. Again, please consider discussing your plan with a parent or qualified professional to assist you in making a decision about your health coverage.

The following resources may also be useful:

Student Health Center
208-496-9330

Affordable Care Act
<http://www.healthcare.gov>

WHO TO CONTACT

For information that is not included in this brochure, or if you have a question, please contact the following offices.

Enrollment and Rate Information

Regular, Away-from-Campus, and Extended Coverage:

Deseret Mutual Enrollment Services
P.O. Box 45530
Salt Lake City, UT 84145
800-777-3622

Student Health Center:

Appointments and Referrals
100 Student Health Center
BYU-Idaho
Rexburg, ID 83460-2010
208-496-9330

Student Health Center Pharmacy:

100 Student Health Center
BYU-Idaho
Rexburg, ID 83460-2010
208-496-9330

Deseret Mutual Customer Service and Preauthorization

150 Social Hall Ave., Ste. 170
P.O. Box 45530
Salt Lake City, UT 84145
800-777-3622 or 801-578-5600

Deseret Mutual's Preferred Provider Network

Find a Contracted Medical Provider:

Southeast Idaho and Utah: Deseret Mutual Contracted Providers
800-777-3622 or www.dmba.com (click on *Find a Provider*)

Hawaii: MDX Contracted Providers
808-675-3972

All other states: UnitedHealthcare Options PPO
www.uhc.com

Access the Student Health Plan Handbook:

www.dmba.com/nsc/Student/Handbooks.aspx

To contact Deseret Mutual online, go to:

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

Frequently Asked Questions

See pages [44 to 46](#) of this handbook.

I'm sick! What should I do?

Is it an emergency?

- Heart attack
- Severe bleeding
- Loss of consciousness
- Convulsions
- Temperature above 104°F
- Severe, sudden onset of symptoms that threaten to impair bodily functions

Get help immediately!

Facility	Copayment
Urgent Care	\$25
Emergency Room	\$50

\$500 deductible applies outside of the SHC

After the emergency

- Call Deseret Mutual at 800-777-3622
- If you're admitted to the hospital or receive emergency care in a physician's office after business hours, call within two business days to preauthorize
 - Call before you receive any follow-up care outside of the SHC

What do I pay to a provider outside of the SHC?

That depends on the services you receive. For more information, see [pages 16 to 24](#) of the Student Plan Handbook.

Is it a non-emergency?

- Family medicine
- Internal medicine
- X-ray and lab services
- Orthopedics
- Pediatrics
- Pharmacy

Go to the Student Health Center (SHC)

Call for an appointment at 208-496-9330. For answers to your medical questions, go to www.byui.edu/healthcenter. You will pay \$10 up front, plus 20% of the remaining bill. If you need to be treated immediately, but the SHC isn't open, go to the nearest urgent care facility or emergency room.

What if the SHC can't treat me?

The SHC will refer you to a contracted medical provider in the community. They will also contact Deseret Mutual to preauthorize the services you're referred to receive.

What if an outside provider recommends additional care?

Before receiving any care that is not specified in an SHC referral, call Deseret Mutual. Preauthorization to see an outside provider does not guarantee payment for every treatment a provider recommends. Make sure you understand plan guidelines, benefits, and exclusions before you receive services.

For more information, see *Frequently Asked Questions* on pages [44 to 46](#).

BYU-IDAHO STUDENT HEALTH PLAN SUMMARY OF BENEFITS

<p>Student Health Center: You and your covered dependents must use the Student Health Center (SHC) as your primary care provider. Additional eligible services at the SHC are paid at 100% after your \$10 copayment. Any service provided outside the SHC requires preauthorization from Deseret Mutual.</p>		
<p>Referrals: If you or your covered dependents are seen by the SHC and need to see a specialist outside the SHC, the SHC will provide you a referral. This referral from the SHC will automatically initiate a request for preauthorization with Deseret Mutual.</p>		
<p>Preauthorization: You must preauthorize all services outside the SHC, except emergency room visits and well-baby care. If you are referred by the SHC, the preauthorization is requested automatically. Otherwise, you must contact Deseret Mutual at 800-777-3622 before you receive the medical care (see page 14).</p>		
<p>Copayments SHC: \$10 for physician services. Outside of SHC: \$25 per service for physician, urgent care, and other outpatient care; \$50 for hospital emergency room visits; \$300 per hospital admission.</p>		
<p>Deductibles: There is a \$500 deductible per person with a \$1,000 plan maximum. For non-student spouses, there is a \$4,750 maternity deductible plus all applicable copayments.</p>		
<p>Maximum Benefit: \$400,000 per person per plan year for services outside the SHC.</p>		
<p>Catastrophe Protection: There is a maximum out-of-pocket responsibility of \$5,000 per person per plan year for services outside the SHC. If your share of eligible charges reaches \$5,000, your benefits for the remainder of the academic year are paid according to the catastrophe protection of the plan, up to your \$400,000 annual plan maximum. For details, see page 26.</p>		
<p>Explanation of Covered Expenses: Plan payments are subject to allowable limits, determined by Deseret Mutual (see page 43).</p>		
COVERED SERVICES	CONTRACTED PROVIDER	NON-CONTRACTED PROVIDER
Ambulance: Licensed land or air transport	80% of allowable charges after copayment	50% of allowable charges after copayment
Ambulatory Surgical Center: Outpatient surgery, services, and supplies	80% of allowable charges after copayment	50% of allowable charges after copayment
Diagnostic X-ray and Lab Services: CT, MRI, ultrasound, lab, and pathology	80% of allowable charges after copayment	50% of allowable charges after copayment
Medical Equipment (Durable): Rental or purchase of eligible equipment (see pages 19-20)	80% of allowable charges after copayment	50% of allowable charges after copayment
Emergency Care: Emergency room services and supplies	80% of allowable charges after copayment	
Home Healthcare: Services and supplies from a home health agency	80% of allowable charges after copayment	50% of allowable charges after copayment
Hospital Medical Services: Room, surgical services and supplies, outpatient medical care	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 Maternity coverage is included for all students. See pages 18 to 19 .	<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 \$250 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 \$250 for routine care
Outpatient Therapy: Chemotherapy, dialysis, mental health, physical, and radiation therapy	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
Prescription Drugs	80% for covered brand-name and generic drugs at the SHC or network pharmacies	
Preventive Care (see table on page 22)	100% of allowable charges; no copayment	50% of allowable charges after copayment

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 Plan handbook. For more information, see *Frequently Asked Questions* on pages [44 to 46](#).

BYU-IDAHO STUDENT HEALTH PLAN SUMMARY OF MATERNITY BENEFITS

<p>General Information: Maternity coverage is included for all students. 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.</p>
<p>Preauthorization: Contact the Student Health Center before you begin your prenatal care with an OB/GYN or Certified Nurse Midwife. To maximize your benefits, you should also call Deseret Mutual at 800-777-3622 to preauthorize care.</p> <p>In addition, you must preauthorize hospital stays of more than two days for a vaginal delivery or four days for a cesarean section delivery. Call Deseret Mutual before your stay is extended.</p>
<p>Copayments Physician/Nurse-Midwife Services: \$25 per visit, up to a total of \$250 for routine care. Hospital Services: \$300 per hospital admission. Newborn infants are considered a separate admission from the mother and will also be subject to the copayment, if they are enrolled in the Student Health Plan.</p>
<p>Deductibles Students: \$500 per person up to a total of \$1,000 per plan. Non-student spouses: \$4,750 plus all applicable copayments (see "Non-student Spouses" below).</p>
<p>Non-student Spouses: Non-student spouses must pay a deductible of \$4,750 before maternity expenses will be covered. After meeting this deductible, benefits are paid according to normal plan provisions (see page 19).</p>

COVERED SERVICES	CONTRACTED PROVIDER	NON-CONTRACTED PROVIDER
Hospital Services	80% of allowable charges after copayment	50% of allowable charges after copayment
Physician/Nurse-Midwife Services	80% of allowable charges after copayment	50% of allowable charges after copayment
Preventive Care (See table on page 22 .)	100% of allowable charges; no copayment	50% of allowable charges after copayment

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 Plan handbook. For more information, see *Frequently Asked Questions* on pages [44 to 46](#).

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INTRODUCTION

Having good health is important for you to achieve your goals at BYU-Idaho. And having adequate medical coverage is important to your good health. Without adequate coverage, unexpected expenses could alter your future dramatically. An accident, illness, or hospitalization could result in a financial burden to you, your family, and the community. For this reason, BYU-Idaho requires all students to have adequate medical coverage.

To help provide this coverage, the BYU-Idaho Student Health Plan was designed to offer a wide range of benefits for students, spouses, and their children at a relatively low cost. This plan is offered by BYU-Idaho and Deseret Mutual provides customer service for the plan.

This 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's your responsibility to become familiar with the plan provisions and guidelines. Exceptions to the plan's contractual provisions cannot be granted.**

UNIVERSITY HEALTH PLAN REQUIREMENT

BYU-Idaho requires all matriculating students to have adequate medical coverage in the Rexburg area as long as they have continuing student status. That means you must have coverage the entire time you are a continuing BYU-Idaho student, including during any semesters you are off-track or other short-term breaks from classes. This requirement will remain in effect until you graduate from BYU-Idaho or lose your continuing student status, whichever comes first.

To satisfy this requirement, you will be enrolled in the Student Health Plan when you first enroll for classes. Testing required by BYU-Idaho will be covered at the on-campus Student Health Center up to seven days before classes begin.

If you are married, your spouse and children will not be enrolled in the plan when you enroll for classes, but you may enroll them by completing a *Dependent Coverage Enrollment Form*. If your spouse is also a student, your spouse will be enrolled when he/she enrolls for classes.

ENROLLMENT

Enrolling Yourself

When you enroll in the plan, you must enroll for the entire school year. If you later obtain health coverage that meets BYU-Idaho's health plan requirement, you may waive Student Health Plan coverage. (For more information, see [page 9](#).)

If you don't enroll for classes for one semester but intend to return the following semester, you must maintain your enrollment in the plan. If you are leaving school for two or more semesters, you may enroll in Extended Coverage. (For more information, see [page 11](#).)

Enrolling Your Family

BYU-Idaho does not require your eligible dependents to be enrolled in the Student Health Plan.

However, if you want to enroll your eligible dependents, you may change your enrollment from individual to family coverage at the beginning of your first semester/block, or at the beginning of each fall semester thereafter.

If you want to change your family's enrollment, remember to notify the Student Health Plan personnel at the Student Health Center.

To enroll your family, go to the Student Health Plan personnel at the Student Health Center. Enrollment forms are due during the first week of classes.

If you are a new student, you must return the form during the first week of your first semester/block. If you are a continuing student, you must return the form during the first week of the next fall semester.

Remember, if you don't enroll your dependents at the beginning of your first semester/block or at the beginning of the fall semester, you can't add them to your coverage midyear. You must wait until the next fall semester unless you meet one of the special circumstances outlined below.

Changing Enrollment Midyear

If you enroll for individual coverage and don't enroll your dependents, you cannot add them to your coverage midyear. However, you have 63 days to enroll new family members acquired through marriage, birth, or adoption. Coverage for a new spouse or stepchildren will begin the first month following your marriage date. Newborns or newborn adopted children are covered on their birth dates; adopted children older than 63 days are covered effective the date they are placed with you. After adding a dependent through birth or adoption, any increase in your plan rate must be paid within 31 days after you have received notice of the billing.

In the case of an adopted child, "placed" means physical placement by a court order in the care of the adoptive subscriber or other member of the covered group. When physical placement is prevented because the child requires care in a medical facility, "placed" means when the adoptive subscriber or other member of the covered group signs agreements for adoption and assumes financial responsibility for the child.

If you waive enrollment in the plan (or if you don't enroll your dependents) because you have other group coverage, but you later lose that coverage, you will be enrolled in the Student Health Plan for the semester/block when coverage was lost. If you want to enroll your dependents as well, you must apply within 63 days of losing the other coverage. If you don't enroll them within this 60-day window, you must wait until the beginning of the following fall semester.

If you enroll in the Student Health Plan, but you later obtain other coverage that meets BYU-Idaho's requirements, you may waive enrollment in the Student Health Plan at the beginning of the next semester/block. To do so, submit an online waiver at www.byui.edu/health-center/student-health-plan before the beginning of the semester/block. Or you may complete a form and submit it to the Student Health Plan personnel at the Student Health Center. You may also drop dependents from coverage at the beginning of any semester/block.

Waiving Enrollment

You may waive Student Health Plan coverage if you have full medical coverage. For accepted coverage that allows you to waive enrollment in the Student Health Plan, see www.byui.edu/health-center/forms.

You must submit [waiver information online](#) or to the Student Health Plan personnel at the Student Health Center before the deadline for each semester (one week after the semester begins).

If your coverage from another health plan ends while you are attending BYU-Idaho, contact the Student Health Plan personnel at the Student Health Center immediately. You must either enroll in the Student Health Plan within 63 days after the coverage ends or provide verification of coverage from another qualified plan.

ELIGIBILITY

The following individuals are eligible to enroll in the Student Health Plan.

Students: You will be enrolled in the plan if you are a matriculating student, unless you certify that you meet the waiver requirement (see above).

Recent Students: Upon loss of continuing student status, you may continue enrollment in the plan for up to four months by enrolling in Extended Coverage (see [page 11](#)).

Dependents: If you enroll in the plan, you may also enroll your eligible dependents, including:

- Your spouse. Your spouse is a person of the opposite sex who is your legal husband or wife.
- Your eligible children. Eligible children are your unmarried children who are younger than 26 including:
 - » Natural children (including infants from date of birth), legally adopted children, and children appointed by a court of law to your custody or your spouse’s custody. In the case of a child who is committed by a court of law to your custody or your spouse’s custody, you must submit a copy of the certified court order granting the adoption, custody, or guardianship.
 - » A child placed with you under the direction of a licensed child placement agency and for which you are the legal guardian.
 - » Your unmarried child who is 26 or older and was medically certified as disabled before the child reached 26, and who is primarily dependent upon you for support.
 - » Your stepchild (child of your spouse) younger than 26. If the stepchild is younger than 18, your spouse must have a court order granting full or partial custody.

COVERAGE

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.

IF YOU ARE ...	YOUR COVERAGE OPTION IS ...
Admitted as a continuing student and enrolled in classes	Regular on-campus coverage
Enrolled in an internship required for your degree or on tour as part of a BYU-Idaho program	Away-from-Campus Coverage (next page)
Admitted as a continuing student but taking a semester/block off	Away-from-Campus Coverage (next page)
Graduated or withdrawn from school	Extended Coverage (optional, next page)

Please be aware that benefits and plan requirements may be different in each option. These differences are noted in this handbook. **Remember, you must preauthorize all services received outside the SHC, other than emergency and well-baby care.**

While You’re Away from BYU-Idaho

In the following instances, you may continue your Student Health Plan coverage even while you are away from the BYU-Idaho campus.

- **Short Breaks from School:** If you enroll in the plan for the academic year and then decide to take a semester off, but you don't withdraw from BYU-Idaho or otherwise lose your continuing student status, you will be covered by the Away-from-Campus option during that semester. For more information, see below.
- **Internships and Student Tours:** If you enroll in the plan and you participate in an internship required by your department or you travel as a member of a BYU-Idaho student tour, you will be covered by the Away-from-Campus option during that semester. For more information, see below.
- **Missions:** If you leave BYU-Idaho to serve a mission, you will not be covered by the plan during that time. You may re-enroll when you return to BYU-Idaho.
- **After Leaving BYU-Idaho:** Within certain limitations, you may continue enrollment in the Extended Coverage option after you graduate or withdraw from BYU-Idaho. For more information, see below.

Away-from-Campus Coverage Option

This option provides coverage for students who are temporarily away from campus and therefore do not have access to the SHC. If you are enrolled in the Student Health Plan for the academic year, you will be enrolled in the Away- from-Campus option while you:

- Participate in an internship.
- Travel as a member of a BYU-Idaho academic tour or performing group on tour.
- Take a temporary break from enrollment in classes on campus (such as an off-track semester or taking the semester off), but do not withdraw from the University or otherwise lose your continuing student status.

If you have enrolled your dependents in the plan, they will also be covered by this option for as long as you are.

While you're enrolled in this option, you must receive medical care at the SHC if you are in the Rexburg area. If you are away from Rexburg, 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. For more information about the Preferred Provider Network, see [page 24](#). **You must still preauthorize any care you receive outside the SHC, other than emergency and well-baby care.**

Extended Coverage Option

Your Student Health Plan coverage ends the day before the beginning of the next semester after you graduate, withdraw, or otherwise lose your continuing student status. If you were enrolled in the plan during your last semester and would like to continue coverage after you leave school, you may enroll in Extended Coverage for up to four (4) consecutive months.

To enroll, pick up an Extended Coverage enrollment form from the Student Health Plan personnel at the Student Health Center and submit it to the BYU-Idaho Health Center at the end of your last semester/ block at BYU-Idaho. You must also pay your plan rate for the first month of coverage.

You must renew your coverage on a month-to-month basis. To do this, submit an enrollment form to the BYU-Idaho Student Health Center 100 SHC Rexburg, ID 83460-2010. If you don't submit your renewal application within five working days of the end of the previous month, it will not be accepted. You must pay your plan rate by the 15th of each month. Please remember these important deadlines! **If you don't renew your coverage in time, it will end and you will not be eligible to re-enroll.**

Your dependents may enroll in Extended Coverage only if they were enrolled in family coverage during your last semester. You may add newly acquired dependents to your coverage as outlined on [page 9](#). If adding a new dependent changes your coverage option and plan rate, the increased rate amount for the month in which the dependent became eligible must be included with the enrollment form within 31 days after you have received notice of the billing.

If 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. For more information about the Preferred Provider Network, see [page 24](#).

Extended Coverage plans are not eligible for Catastrophe Protection (see [page 26](#)).

Coverage Periods

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

You have 63 days to enroll new family members acquired through marriage, birth, or adoption. Coverage for a new spouse or stepchildren will begin the first month following your date of marriage. Newborns or newborn adoptive children have coverage on their date of birth; adoptive children older than 63 days will have coverage effective on their date of placement with you. After adding a dependent due to an adoption, you have 31 days to pay any applicable plan rate increase.

After your coverage ends, you may request a document, similar to a Certificate of Creditable Coverage, certifying the length of time you were enrolled in the Student Medical Benefit by calling Deseret Mutual.

WHEN DOES COVERAGE BEGIN?	FOR YOU AND CURRENT DEPENDENTS	FOR A NEW DEPENDENT
Regular on-campus or Away-from-Campus coverage	First day of classes for new semester/block	12:01 a.m. on the date of the qualifying event
Extended Coverage	12:01 a.m. on the day after your Regular On-Campus or Away-from-Campus coverage ends	12:01 a.m. on the date of the qualifying event
WHEN DOES COVERAGE END?	AFTER YOU GRADUATE, LOSE CONTINUING STUDENT STATUS, OR GAIN OTHER COVERAGE	AFTER YOUR DEPENDENT LOSES ELIGIBILITY
Regular on-campus or Away-from-Campus coverage	Last day before the next semester/block begins	Last day before the beginning of the semester following the semester in which the dependent becomes ineligible
Extended Coverage	12:01 a.m. on the first day of the month after the last month for which the plan rate has been paid	

Coverage at Other Church Universities

If you receive services at the SHC of another Church university, you will be covered as if you had received services at the BYU-Idaho SHC. You must pay the SHC copayment at the time of service. You don’t need preauthorization.

UNIVERSITY HEALTH PLAN RATES

Rate payments are due at the same time as tuition for each semester or block. For the exact dates that rate payments are due, see the dates on [pages 32-33](#).

If you change enrollment midyear, your plan rate (or increased rate, if necessary) will be due immediately when you enroll for the semester/block in which the change becomes effective.

	REGULAR ON-CAMPUS AND AWAY-FROM-CAMPUS COVERAGE	EXTENDED COVERAGE
Student Only (Single Coverage)	Semester: \$546 Block: \$273	\$290 per month
Student Plus Dependent(s)	Semester: \$2,172 Block: \$1,086	\$808 per month

HOW THE PLAN WORKS

Overview

You should receive or coordinate all your medical care at the SHC (see [page 15](#)). When you receive services at the SHC, you pay an up front office visit fee of \$10. All eligible services performed at the SHC during your visit are then covered by the plan at 100%. If the SHC cannot treat you, you will be referred to a medical provider in the community.

If you receive authorized services outside the SHC, you pay an up-front copayment to the medical provider. A copayment is a fixed dollar amount (usually \$25) that you owe at the time services are received.

After you pay your copayment, the amount covered by the plan is your plan benefit (for example, 80%). The remaining 20% is your responsibility.

Plan benefits will not be paid for services received outside the SHC until you meet your annual deductible of \$500 per person, up to \$1,000 per family (see [page 14](#)). Also, non-student spouses must meet a \$4,750 deductible for maternity expenses. This means that non-student spouses need to pay the first \$4,750 of the cost for their prenatal care and the delivery of the baby. Regular plan benefits apply to eligible expenses over \$4,750. For more information, see [page 19](#).

If you receive services outside the SHC, you or your medical provider must submit an itemized bill to Deseret Mutual (see [page 25](#)). Deseret Mutual will process your claim, send a check for the plan benefit to the medical provider, 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 responsibility. You must pay your copayment (if you haven't already done so) and the remaining charges to the medical provider.

In some cases, the medical provider will bill more than Deseret Mutual's allowable limit for the services you received (see definition on [page 43](#)). If so, your explanation of benefits statement will also itemize how much of the bill is over the allowable limit.

- If you receive your care from one of Deseret Mutual's contracted providers, you don't have to pay any amount over the allowable limit. When healthcare providers contract with Deseret Mutual, they agree not to bill you for more than the allowable limit. (For information about contracted providers, see [page 24](#).)
- If you receive your care from a provider who is not contracted with Deseret Mutual, you are responsible to pay any charges over the allowable limit.

You are also responsible to pay your medical provider for any services that aren't covered by the plan. For more definitions of terms used in this handbook, see [page 42](#).

Student Health Plan Identification Card

You may obtain a copy of your health plan card by going to www.dmba.com, creating a password, and then printing the card. You may request a card from Deseret Mutual by calling 800-777-3622.

Copayments and Office Visit Fees

You should receive or coordinate all your medical care at the SHC (see [page 15](#)). If the SHC cannot treat you, you will be referred to a medical provider in the community. Your office visit fees and copayments are as follows:

SERVICES AT THE SHC	SERVICES OUTSIDE THE SHC
Physician services: \$10 per visit	Physician services, outpatient care, and urgent care: \$25 copayment
	Hospital emergency room: \$50 copayment
	Hospital admission: \$300 copayment

Plan Benefits and Your Responsibility

After you have paid your office visit fee or copayment, benefits for the remainder of eligible expenses are:

	SERVICES AT THE SHC	SERVICES OUTSIDE THE SHC
The plan pays:	100% for lab and X-ray	Contracted providers: 80% Non-contracted providers: 50%
You pay:	0% for lab and X-ray	Contracted providers: 20% Non-contracted providers: 50%

Maximum Plan Benefit

The maximum benefit is \$400,000 per person per academic year. For information about Catastrophe Protection, please see [page 26](#).

Deductibles

There is a \$500 annual deductible per person (up to \$1,000 per family) for services received outside the SHC. This means that every plan year you must pay the first \$500 of eligible medical expenses before you begin to receive plan benefits. Remember to send your claims to Deseret Mutual so that your deductible amounts can be tracked.

SERVICES AT THE SHC	SERVICES OUTSIDE THE SHC	
Deductible does not apply	Preventive services and pharmacy	Deductible does not apply
	Eligible services	\$500 individual (up to \$1,000 per family)
	Non-student spouse maternity expenses	Additional \$4,750 deductible (see page 19 for details)

The plan year for all deductibles runs concurrent with the academic year.

Preauthorization

For services from a provider outside the SHC, **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 referral from the SHC (such as additional office visits, tests at another facility, or consultation with another healthcare provider), **you must contact Deseret Mutual for preauthorization before you receive the additional care.** Remember, care beyond the scope of the original SHC referral must also be authorized in advance by Deseret Mutual. Preauthorization requests will be responded to within two days.

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

STUDENT HEALTH CENTER

The Student Health Center (SHC) provides or coordinates all medical care that is covered by the plan. If you need eligible services that the SHC can't provide, you'll 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.

The SHC is located on the first floor of the Student Health and Counseling Center. It is open to all students, spouses, and dependents who are covered by the Student Health Plan.

Available Services

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

- Diagnostic X-ray, non-maternity ultrasound, and laboratory services
- Family medicine
- Internal medicine
- Orthopedics
- Pediatrics
- Pharmacy
- Premarital exams
- Routine physical exams
- Well-baby care

Payment for Services

You are responsible for all costs incurred during each visit to the SHC except for the portion that is covered by the Student Health Plan.

Your SHC visit fee is \$10. All other eligible SHC services in addition to the visit fee are covered at 100%.

Operating Hours

SHC hours are as follows (last appointment available one-half hour before closing):

MONDAYS, WEDNESDAYS, THURSDAYS, FRIDAYS	TUESDAYS	EXCEPTIONS
8 a.m. to 5 p.m.	8 a.m. to 11:15 a.m. and 12:30 p.m. to 5 p.m.	Closed holidays and selected days during break between fall and winter semester

BENEFITS ARE PAID AFTER YOU MEET THE ANNUAL DEDUCTIBLE (\$500 PER PERSON UP TO \$1,000 PER FAMILY)

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. **You must preauthorize all care you receive outside the SHC, except for emergency and well-baby care. Also, benefits are paid after you meet the annual deductible** (\$500 per person, up to \$1,000 per family).

Not all services are covered by the plan. To see which services are not covered, carefully read the exclusions beginning on [page 27](#).

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

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%.

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%.

DENTAL ACCIDENT BENEFIT

- The plan pays 80% after your \$25 copayment; you pay 20%.
- The maximum benefit is \$3,000 per academic 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 covered by the plan and within two years of the accident.

DIABETES EDUCATION

- The plan pays 80% after your \$25 copayment; you pay 20%.
- The maximum benefit is \$300 per academic year.

DIABETIC SUPPLIES

- The plan pays 80%; you pay 20%.

BENEFITS ARE PAID AFTER YOU MEET THE ANNUAL DEDUCTIBLE (\$500 PER PERSON UP TO \$1,000 PER FAMILY)

DIALYSIS

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

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 follow-up care with Deseret Mutual.
- If an urgent care facility is appropriate and available as a less expensive alternative, please see [page 24](#).

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 academic year.
- Eye exams for medical conditions, such as glaucoma, may be eligible for benefits more often. Additional benefits must be preauthorized.

HEARING TESTING

- 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%.

HOME HEALTHCARE

- 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.**
- For more information, contact Deseret Mutual.

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 \$300 copayment per admission.
- The plan covers any prescription drugs that are administered as part of an inpatient hospital service.

INPATIENT PHYSICIAN SERVICES

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

BENEFITS ARE PAID AFTER YOU MEET THE ANNUAL DEDUCTIBLE (\$500 PER PERSON UP TO \$1,000 PER FAMILY)

LABORATORY SERVICES

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

MAMMOGRAPHY

- Routine mammograms are eligible for benefits as follows:
 1. One baseline mammogram for ages 35 through 39.
 2. One mammogram every two years for ages 40 through 49, or more frequently upon recommendation of a physician.
 3. One mammogram every year for ages 50 and older.
 4. One mammogram for any woman desiring a mammogram for medical necessity.

MATERNITY—GENERAL INFORMATION

- Non-student spouses: Expenses of more than \$4,750 will be covered, subject to normal plan provisions (see *Maternity—Non-Student Spouse* on [page 19](#)).
- Contact the Student Health Center before you begin your prenatal care with an OB/GYN or Certified Nurse Midwife. **To maximize your benefits, you should also contact Deseret Mutual to preauthorize care.**
- The Student Health Plan complies with the Newborns' and Mothers' Health Protection Act of 1996.

MATERNITY—STUDENTS

Hospital services:

- Contracted provider: The plan pays 80%; you pay 20%.
- Non-contracted provider: The plan pays 50%; you pay 50%.
- You pay a \$300 copayment per admission. (Newborn infants are considered a separate admission from the mother and will also be subject to the copayment, if they are enrolled in the Student Health Plan.)
- When you deliver at a contracted hospital, services are provided at discounted rates.
- **You must preauthorize medically necessary hospital stays 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. For preauthorization, contact Deseret Mutual before your stay is extended. Preauthorization requests will be responded to within two days.
- 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 hospital copayments will apply to these charges.

Physician/certified 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 \$250 for routine care).
- For students, regular plan benefits apply to all eligible maternity expenses. For information on non-student spouse benefits, see *Maternity—Non-Student Spouse*, which follows.
- When you receive care from a contracted provider in Rexburg, services are provided at discounted rates.
- The contracted rates are for prenatal care and delivery provided by one physician throughout the term of the pregnancy. **If you are away from Rexburg for part of the pregnancy, or if your care must be provided by more than one doctor, be sure to get preauthorization.**

BENEFITS ARE PAID AFTER YOU MEET THE ANNUAL DEDUCTIBLE (\$500 PER PERSON UP TO \$1,000 PER FAMILY)

- 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 also apply to these charges.
- Remember, 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, contact the Student Health Plan personnel at the Student Health Center within 63 days of the birth (see [page 9](#)).

MATERNITY–NON-STUDENT SPOUSE

For non-student spouses, benefits are available only for eligible expenses of more than \$4,750. The first \$4,750 of expenses (as shown below) will be your responsibility. The \$4,750 deductible also applies to expenses related to pre-term labor or miscarriage. The \$4,750 deductible applies to expenses resulting from normal delivery and cesarean section delivery. Expenses for cesarean section delivery in excess of the deductible will be treated as expenses for any other illness under the plan.

Hospital services:

- You pay a \$2,850 deductible and copayment for the mother's hospital bill. This includes the \$300 hospital copayment.
- You pay a \$300 deductible and copayment for the baby's hospital bill, if they are enrolled in the Student Health Plan.
- Contracted provider: The plan pays 80% of the remaining eligible expenses; you pay 20%.
- Non-contracted provider: The plan pays 50% of the remaining eligible expenses; you pay 50%.

Physician/certified nurse-midwife services:

- You pay a \$1,900 deductible and copayment for the mother's physician bill for prenatal care and delivery. This includes the \$250 maximum physician copayment.
- Contracted provider: The plan pays 80% of the remaining eligible expenses; you pay 20%.
- Non-contracted provider: The plan pays 50% of the remaining eligible expenses; you pay 50%.

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 see 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.

BENEFITS ARE PAID AFTER YOU MEET THE ANNUAL DEDUCTIBLE (\$500 PER PERSON UP TO \$1,000 PER FAMILY)

MEDICAL EQUIPMENT

This table is not intended to be all-inclusive.

MUST BE PREAUTHORIZED	DOES NOT NEED TO BE PREAUTHORIZED	IS NOT ELIGIBLE FOR BENEFITS
Airway clearance systems (ThAIRpy vests) Bone growth stimulators Breast pumps (for NICU stays only) Communication devices CPM machines Enteral infusion pumps/formula Eyeglasses/contact lenses (with certain medical diagnoses and/or surgeries) Gait trainers Helmet therapy Hospital beds/mattresses Hoyer lifts Insulin pumps Intermittent limb compression devices Lymph presses Orthotics Oxygen concentrators/tanks Respirators/ventilators Scooters Standers TENS units/EMS units Wheelchairs	Apnea monitors (newborns only) Bilirubin lights Blood pressure kits Canes Commodes Crutches Glucometers (contact MRx) Nebulizers/Pulmo-Aides Orthopedic braces Overhead trapeze Oxygen, stationary* Pacemakers Reflux boards Transfer boards Walkers	Air filtration systems Continuous glucose monitors Exercise equipment Eyeglasses/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

* Preauthorization is required after 30 days

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% after your \$25 copayment; you pay 20%.
- Non-contracted provider: The plan pays 50% after your \$25 copayment; you pay 50%.
- Residential treatment is not covered.
- To be eligible for benefits, services must be provided by a physician, psychologist, clinical social worker, or advanced practice registered nurse.
- You must preauthorize all mental health services outside the SHC.

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%.
- You do not need to preauthorize well-care visits for children.

BENEFITS ARE PAID AFTER YOU MEET THE ANNUAL DEDUCTIBLE (\$500 PER PERSON UP TO \$1,000 PER FAMILY)

- **Students, spouses, and other dependents must preauthorize unless you are enrolled in the Away-from-Campus or Extended Coverage option** (see [page 11](#)).

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.
- 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.

PHYSICAL THERAPY–OUTPATIENT

- 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 plan covers up to 20 visits per person per academic year.
- Inpatient visits do not count toward your annual outpatient visit limit.
- You may receive preauthorization for a series of visits at one time.

PRESCRIPTION DRUGS

At SHC pharmacy and at network retail pharmacies:

- High-cost and specialty drugs are excluded by the plan.
- Covered Brand and Generic Drugs: The plan pays 80%; you pay 20%.
- Non-covered Brand and Generic Drugs: You pay 100%.
- Benefits are limited to a 30-day supply.
- Prescription drugs are not included in Catastrophe Protection (see [page 26](#)). If you qualify for Catastrophe Protection, standard prescription benefits will remain in effect.

Documented university-sponsored international travel for may allow for a supply 1) up to 90 days or 2) until the end of your recorded enrollment in the SHP, whichever comes first. For more information, call VRx at 801-417-9722 or 877-879-9722.

For more information about covered drugs and retail pharmacy locations, call Deseret Mutual at 801-578-5600 in the Salt Lake City area or toll free at 800-777-3622. Or call VRx at 801-417-9722 or 877-879-9722.

PREVENTIVE SERVICES

- Contracted provider: The plan pays 100%; no copayment applies.
- Non-contracted provider: The plan pays 50% after your \$25 copayment; you pay 50%.
- To be covered by the Student Health Plan, you must buy over-the-counter preventive medicines at a network pharmacy.
- See the table on [page 22](#) for a list of covered services and general information.
- For more information about mandated preventive service coverage, call Deseret Mutual at 801-578-5600 in the Salt Lake City area or toll free at 800-777-3622.

BENEFITS ARE PAID AFTER YOU MEET THE ANNUAL DEDUCTIBLE (\$500 PER PERSON UP TO \$1,000 PER FAMILY)

SERVICES FOR ADULTS (AGES 19+)	SERVICES FOR WOMEN
<ul style="list-style-type: none"> • Abdominal Aortic Aneurysm one-time screening for men of specified ages who have ever smoked. • Alcohol Misuse screening and counseling. • Aspirin use for men and women of certain ages. • Blood Pressure screening for all adults. • Cholesterol screening for adults of certain ages or at higher risk. • Colorectal Cancer screening for adults over 50. • Depression screening for adults. • Type 2 Diabetes screening for adults with high blood pressure. • Diet counseling for adults at higher risk for chronic disease. • HIV screening for all adults at higher risk. • Immunization vaccines for adults—doses, recommended ages, and recommended populations vary. • Obesity screening and counseling for all adults. • Sexually Transmitted Infection (STI) prevention counseling for adults at higher risk. • Tobacco Use screening for all adults and cessation interventions for tobacco users. • Syphilis screening for all adults at higher risk. 	<ul style="list-style-type: none"> • Anemia screening on a routine basis for pregnant women. • Bacteriuria urinary tract or other infection screening for pregnant women. • BRCA counseling about genetic testing for women at higher risk. • Breast Cancer Mammography screenings every one to two years for women over 40. • Breast Cancer Chemoprevention counseling for women at higher risk. • Breastfeeding comprehensive support and counseling from trained providers, as well as access to breastfeeding supplies, for pregnant and nursing women. • Cervical Cancer screening for sexually active women. • Chlamydia Infection screening for younger women and other women at higher risk. • Domestic and interpersonal violence screening and counseling for all women. • Folic Acid supplements for women who may become pregnant. • Gestational diabetes screening for women 24 to 28 weeks pregnant and those at high risk of developing gestational diabetes. • Gonorrhea screening for all women at higher risk. • Hepatitis B screening for pregnant women at their first prenatal visit. • Human Immunodeficiency Virus (HIV) screening and counseling for sexually active women. • Human Papillomavirus (HPV) DNA Test: high risk HPV DNA testing every three years for women with normal cytology results who are 30 or older. • Osteoporosis screening for women over age 60 depending on risk factors. • Rh Incompatibility screening for all pregnant women and follow-up testing for women at higher risk. • Tobacco Use screening and interventions for all women, and expanded counseling for pregnant tobacco users. • Sexually Transmitted Infections (STI) counseling for sexually active women. • Syphilis screening for all pregnant women or other women at increased risk. • Well-woman visits to obtain recommended preventive services for women under 65.
SERVICES FOR CHILDREN AND ADOLESCENTS (AGES 0-18)	
<ul style="list-style-type: none"> • Alcohol and Drug Use assessments for adolescents. • Autism screening for children at 18 and 24 months. • Behavioral assessments for children of all ages. • Blood Pressure screening for children. • Cervical Dysplasia screening for sexually active females. • Congenital Hypothyroidism screening for newborns. • Depression screening for adolescents. • Developmental screening for children under age 3, and surveillance throughout childhood. • Dyslipidemia screening for children at higher risk of lipid disorders. • Fluoride Chemoprevention supplements for children without fluoride in their water source. • Gonorrhea preventive medication for the eyes of all newborns. • Hearing screening for all newborns. • Height, Weight and Body Mass Index measurements for children. • Hematocrit or Hemoglobin screening for children. • Hemoglobinopathies or sickle cell screening for newborns. • HIV screening for adolescents at higher risk. • Immunization vaccines for children from birth to age 18—doses, recommended ages, and recommended populations vary. • Iron supplements for children ages 6 to 12 months at risk for anemia. • Lead screening for children at risk of exposure. • Medical History for all children throughout development. • Obesity screening and counseling. • Oral Health risk assessment for young children. • Phenylketonuria (PKU) screening for this genetic disorder in newborns. • Sexually Transmitted Infection (STI) prevention counseling and screening for adolescents at higher risk. • Tuberculin testing for children at higher risk of tuberculosis. • Vision screening for all children. 	

BENEFITS ARE PAID AFTER YOU MEET THE ANNUAL DEDUCTIBLE (\$500 PER PERSON UP TO \$1,000 PER FAMILY)

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.

RADIATION THERAPY

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

RADIOLOGY SERVICES (X-RAYS, CT SCANS, MRIS, ETC.)

- The plan pays 80% after your \$25 copayment; you pay 20%.
- Routine mammograms are eligible for benefits as follows:
 1. One baseline mammogram for ages 35 through 39.
 2. One mammogram every two years for ages 40 through 49, or more frequently upon recommendation of a physician.
 3. One mammogram every year for ages 50 and older.
 4. One mammogram for any woman desiring a mammogram for medical necessity.

SKILLED NURSING

- 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.
- Time in an extended care facility must occur after an inpatient hospitalization.
- If the care is for recuperating or convalescing from an acute injury or illness, the maximum benefit is 50 days per academic year.
- Custodial care (such as maintaining someone beyond the acute phase of injury or illness, including room, meals, bathing, and dressing) is not covered.

SUBSTANCE ABUSE

- Contracted provider: The plan pays 80% after your \$25 copayment (for outpatient services); you pay 20%.
- Non-contracted provider: The plan pays 50% after your \$25 copayment; you pay 50%.
- Residential treatment is not covered.
- You must preauthorize.

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%.

SURGERY—OUTPATIENT HOSPITAL SERVICES

- Contracted provider: The plan pays 80% after your \$200 copayment; you pay 20%.
- Non-contracted provider: The plan pays 50% after your \$200 copayment; you pay 50%.

BENEFITS ARE PAID AFTER YOU MEET THE ANNUAL DEDUCTIBLE (\$500 PER PERSON UP TO \$1,000 PER FAMILY)

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%.

URGENT CARE FACILITY

- 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.
- For more information about what to do in an emergency, see [page 25](#).

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 don't need to preauthorize well-baby care.

WOMEN'S HEALTH AND CANCER RIGHTS ACT

The Women's Health and Cancer Rights Act of 1998 provides benefits for mastectomy-related services including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses and complications resulting from the mastectomy, including lymphedema. Call Deseret Mutual at 800-777-3622 for more information.

- 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%.

DESERET MUTUAL'S PREFERRED PROVIDER NETWORK

If you are away from the Rexburg area while you're enrolled in the Student Health Plan, you may obtain care from any qualified, appropriately licensed medical provider. However, it's to your advantage to make sure the physicians and hospitals providing your care are contracted as 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 allowable amounts.

This network extends throughout most areas of the United States, and includes physicians and hospitals that provide quality care at substantially discounted rates.

For information about providers in your area, please see the following networks.

Find a contracted medical provider:

Utah and Southeast Idaho: Deseret Mutual Contracted Providers
800-777-3622 or www.dmba.com (click on *Find a Provider*)

Hawaii: MDX Contracted Providers
808-675-3972

All other states: UnitedHealthcare Options PPO
www.uhc.com

Remember, eligible expenses for services from contracted providers are covered at 80% while eligible expenses from non-contracted providers are covered at 50%.

EMERGENCIES

In an emergency, you should always get the appropriate care immediately. For non-life threatening situations, you'll pay a \$10 office copayment at the SHC. At an urgent care facility, you'll pay a \$25 copayment plus 20% of the remaining charges. At a hospital emergency room, you'll pay a \$50 copayment plus 20% of the remaining charges.

Life-threatening Emergencies

If you are faced with a life-threatening emergency, you should seek immediate medical treatment from a qualified, accessible provider. Plan benefits for treatment outside the SHC will apply.

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

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 while the SHC is open, you should obtain care from the SHC.

If any emergency occurs when the SHC is closed, you should go to the Madison Memorial Hospital emergency room. Plan benefits for treatment outside the SHC will apply.

If you receive services in an emergency room and you are subsequently admitted to the hospital, you must call Deseret Mutual to preauthorize the admission within two business days. **If you receive emergency care in a physician's office after business hours, you must also call Deseret Mutual for preauthorization.**

Follow-up to Emergency Care

For all emergencies, contact Deseret Mutual at 800-777-3622 before you receive any follow-up care. If you need to receive follow-up care outside the SHC, you must preauthorize with Deseret Mutual before you receive the care.

SUBMITTING CLAIMS FOR PAYMENT

To receive plan benefits for services provided outside the SHC, submit an itemized bill and claim form (available from Deseret Mutual), along with the preauthorization, to:

Student Health Plans
Deseret Mutual
P.O. Box 45530
Salt Lake City, UT 84145

If you receive services outside Southeast Idaho, Utah, or Hawaii your provider should send claims directly to UnitedHealthcare. The address is on the back of your Student Health Plan ID card.

To be eligible for coverage, claims must be submitted within 12 months of the date of service. You don't need to submit claims for services received at the SHC.

Claims Payment Timelines

We'll pay or deny electronic claims within 30 days of receiving them. We'll pay or deny paper claims within 45 days of receiving them.

If we deny a claim or need more information, we'll contact the provider or facility within 30 days of receiving an electronic claim, or 45 days of receiving of a paper claim.

If we deny a claim because we need more information, and the provider submits the information within 30 days, then we'll reprocess the claim within 30 days of receiving the information.

CATASTROPHE PROTECTION

If your share of eligible expense reaches a certain limit per academic year (your annual maximum responsibility), your benefits for the remainder of the academic year are paid according to the catastrophe protection of the plan, up to your \$400,000 annual plan maximum benefit.

For individuals (students and/or dependents) covered by the BYU-Idaho Student Health Plan, after your share of eligible expenses reaches \$5,000, benefits increase to 100% for eligible charges (up to \$400,000), based on Deseret Mutual's allowable limits.

However, catastrophe protection does not apply to all benefits. You will continue to be responsible for copayments and amounts not covered by the plan on the following benefits:

- Hospital emergency room
- Mental health—outpatient care
- Office visits
- Therapy (such as physical therapy)
- Urgent care facility

Also, expenses for the following services do not apply to your annual maximum responsibility and are not covered by the catastrophe protection of the plan:

- Infusion therapy drugs purchased through your physician's office
- Prescription drugs

Finally, the following expenses do not apply to your annual maximum responsibility and are not covered by the catastrophe protection of the plan:

- Amounts that exceed the allowable limits
- Annual deductibles
- Ineligible amounts
- Non-student spouse maternity deductible
- Rate payments
- Any other expenses not covered by the plan

REPATRIATION OF REMAINS

If a covered accident or illness causes the death of a covered 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 \$25,000. To be eligible for coverage, expenses must be approved in advance. For more information, call Deseret Mutual at 801-578-5600 or 800-777-3622.

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:

1. Alternative care

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

2. Congenital anomalies

- 2.1 Care, treatment, or operations to treat congenital anomalies in individuals 19 years of age and older that are 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 newborns or individuals under age 19.

3. Convenience/cosmetic services

- 3.1 Care, treatment, supplies, or other services incurred primarily for convenience, contentment, or other non-therapeutic purposes, or are not clearly a medical necessity
- 3.2 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 the plan. This exclusion does not apply to care, treatment, or operations to treat congenital anomalies in individuals up to (but not including) 19 years of age.
- 3.3 Care, treatment, diagnostic procedures, or other expenses for an abdominoplasty, breast reduction, lipectomy, panniculectomy, skin furrow removal, or diastasis rectus repair

4. Custodial care

- 4.1 Custodial care, education, training, or rest cures
- 4.2 Inpatient hospitalization or residential treatment for the primary purpose of providing shelter and/or safe residence

5. Dental care

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

6. Diagnostic and experimental services

- 6.1 Care, treatment, diagnostic procedures, or operations that are:
 - 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

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

Investigative/experimental technology means treatment, procedure, facility, equipment, drug, device, or supply that does not, as determined by Deseret Mutual on a case-by-case basis, meet all of the following criteria:

- The technology must have final approval from all appropriate governmental regulatory bodies, if applicable.
- The technology must be available in significant number outside the clinical trial or research setting.
- The available research about the technology must be substantial. For plan purposes, substantial means sufficient to allow Deseret Mutual to conclude the technology is:
 - » Both medically necessary and appropriate for the covered person's treatment
 - » Safe and efficacious
 - » More likely than not will be beneficial to the covered person's health

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

7. Educational programs

7.1 Educational programs (PMS clinics, etc.) except diabetes education

8. Fertility/family planning/home delivery

8.1 Reproductive organ prostheses

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

8.3 Care, treatment, or operations in connection with infertility

8.4 Care, treatment, or operations in relation to in vitro fertilization

8.5 Elective abortions, meaning an abortion for any reason other than to preserve the life of the female upon whom the abortion is performed

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

8.7 Planned home delivery for childbirth and all associated costs

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

8.9 All services and expenses related to a surrogate pregnancy including but not limited to care, treatment, delivery, diagnostic procedures, or operations, as well as maternity care for the surrogate mother and prenatal/postnatal care for the newborn child are excluded. All services and expenses for complications related to a surrogate pregnancy are also excluded.

All services and expenses related to a pregnancy resulting in an adoption including but not limited to care, treatment, delivery, diagnostic procedures, or operations, as well as maternity care for the surrogate mother and prenatal/postnatal care for the newborn child are excluded. All services and expenses for complications related to a pregnancy resulting in adoption are also excluded.

9. Government/war

- 9.1 Services required as a result of 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.

10. Hearing

- 10.1 The purchase or fitting of hearing devices

11. Legal Exclusions

- 11.1 Accidents sustained as a result of play, practice, or participation in professional activities (including intercollegiate sports and vehicular contests)
- 11.2 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
- 11.3 Services that the individual is not, in the absence of this coverage, legally obligated to pay
- 11.4 Services or materials covered or that could have been covered by insurance required or provided by any statute, including but not limited to no-fault, underinsured motorist, medical liability, and uninsured motorist insurance, except as provided at the SHC
- 11.5 Conditions resulting from catastrophic events defined as an earthquake, fire, 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
- 11.6 Complications resulting from excluded services
- 11.7 Services not specified as covered
- 11.8 Care, treatment, or operations incurred after coverage ends

12. Medical equipment

- 12.1 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 20](#)
- 12.3 Modifications to homes, other structures, or motor vehicles to accommodate activities of daily living

13. Medical necessity

- 13.1 Care, treatment, or operations that are not clearly a medical necessity. Medically Necessary: Services or supplies that are proper and needed for a legitimate diagnosis or a cost-efficient treatment of your medical condition; are used for the diagnosis, direct care, and treatment of your medical condition; meet the standards of good medical practice in the local community; and are not mainly for the convenience of you or your doctor.
- 13.2 Treatment or removal of warts, toenails, corns, calluses, or bunions outside the SHC
- 13.3 Care, treatment, or operations for bunions
- 13.4 Cardiopulmonary fitness training or conditioning (meaning reimbursement for gym, health, or fitness club memberships or fees), either as a preventive or therapeutic measure

14. 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
- 14.3 Care or treatment for mental health, counseling, or substance abuse rendered in a residential treatment center or partial hospitalization setting.
- 14.4 Evaluation and/or treatment for learning disabilities and/or physical or mental developmental delay, including pervasive developmental disorders, autism, and/or cognitive dysfunctions.

15. Miscellaneous

- 15.1 Physical exams for the purpose of obtaining coverage, employment, or government licensing
- 15.2 Care, treatment, diagnostic procedures, equipment, or any other services for sleep disorders, chronic fatigue, or fibromyalgia
- 15.3 Deseret Mutual excludes sex change operations and all associated procedures and services (medical, psychological, pharmaceutical, surgical, etc.) from benefits in all medical plans.
- 15.4 Care, treatment, diagnostic procedures, or other expenses when it has been determined by an attending physician that brain death has occurred
- 15.5 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

16. Obesity

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

17. Other coverage/workers' compensation

- 17.1 Services covered or that could have been covered by applicable workers' compensation statutes
- 17.2 Services that a third party, the liability coverage of a third party, or the uninsured motorist coverage pays or is obligated to pay

18. Plan coverage

- 18.1 Services provided before coverage begins, including hospital stays in progress on the effective date of coverage and services after coverage ends

19. Prescription drugs, specialty pharmacy medications, formulas, and supplements

- 19.1 Dietary products, nutritional or food supplements, and special diets except to the extent specifically provided in the plan (including any requirements regarding preauthorization)
- 19.2 Excluded medications such as contraceptive pills for birth control, dietary or nutritional products and/or supplements (including special diets for medical problems), herbal remedies, homeopathic treatments, products used to stimulate hair growth, medications used for sexual dysfunction, medications whose use is for cosmetic purposes, over-the-counter products, vitamins, weight reduction aids, and non-federal legend status drugs

20. Routine services

20.1 Physical examination for the purpose of obtaining health coverage, employment, government licensing, or as needed for volunteer work unless otherwise provided for by the terms of the plan

21. Speech therapy

21.1 Speech therapy and evaluation

22. TMJ

22.1 Services and materials in connection with disturbances of the temporomandibular joint (TMJ)

22.2 Jaw surgery (osteotomy)

23. Testing

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

23.2 Some allergy tests including but not limited to Leukocyte Histamine Release Test (LHRT), cytotoxic food testing (Bryan's Test, ACT), Conjunctival Challenge Test (electro-acupuncture), Passive Transfer (PX) or Prausnitz- Kustner (PK) Test, Provocative Nasal Test, provocative food and chemical testing (intradermal, subcutaneous, or sublingual), Rebeck Skin Window Test, Rinkel Test, and skin endpoint titration

24. Transplants

24.1 Medications, care, treatment, diagnostic procedures, or operations in relation to transplants (donor or artificial)

25. Vision

25.1 Eyeglasses and contact lenses or the replacement or prescription thereof

25.2 Care, treatment, diagnostic procedures, or any other expenses for elective surgeries to correct vision including radial keratotomy or LASIK surgery, unless otherwise provided for by the terms of the plan

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

BYU-Idaho 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 website at www.dmba.com/nsc/Student/Handbooks.aspx.

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 coverage or statement of claim containing any materially false or misleading information may lead to reduction, denial, or termination of benefits or coverage under the plan and recovery of any amounts Deseret Mutual may have paid. Non-compliance with a contract prepared by Deseret Mutual addressing abuse of healthcare benefits or systems may also lead to reduction, denial, or termination of benefits or coverage under the plan and recovery of any amounts Deseret Mutual may have paid.

LEGAL NOTICE

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

IMPORTANT DATES

Fall Semester 2020

September 14.....Classes start and coverage begins
 September 21.....Fall open enrollment ends; last day to waive coverage
 December 16 Classes end
 January 5 Fall semester coverage ends

Fall Second Block 2020

October 28.....Classes start and coverage begins
 November 4.....Second block Student Health Plan registration deadline
 December 16 Classes end
 January 5 Coverage ends

Winter Semester 2021

January 6.....Classes start and coverage begins
 January 13.....Winter open enrollment ends; last day to waive coverage
 April 8 Classes end
 April 18 Winter semester coverage ends

Winter Second Block 2021

February 22Classes start and coverage begins
 March 1Second block Student Health Plan registration deadline
 April 8 Classes end
 April 18 Coverage ends

Spring Semester 2021

April 19Classes start and coverage begins
 April 26Spring open enrollment ends; last day to waive coverage
 July 20..... Classes end
 September 12..... Spring semester coverage ends

Spring Second Block 2021

June 3.....Classes start and coverage begins
 June 10.....Second block Student Health Plan registration deadline
 July 20..... Classes end
 September 12..... Coverage ends

Summer Session 2021

July 26.....Classes start and coverage begins
 September 12..... Summer session coverage ends

INTERNAL CLAIMS PROCEDURES

This internal claims procedure applies to each health and welfare benefit offered under the BYU-Idaho Student Health Plan. Claims for benefits and subsequent appeals under the plan will be filed in accordance with the procedures set forth in this section of the plan handbook and any subsequent amendments, schedules, or attachments thereto.

Initial Claim

You may initiate a claim for benefits by contacting Deseret Mutual. Deseret Mutual will inform you of the information required to complete the claim, that may vary depending on the type of benefit and may include:

- A completed electronic or paper claim form, in a format provided by Deseret Mutual.
- Reasonable documentation from the Student Health Center physician or other provider or official describing and/or verifying the injury, illness, or other condition or event giving rise to your claim.
- Copies of bills for services rendered, including your name; the provider’s name, address, and telephone number; the diagnosis; the type(s) of service rendered, with diagnosis and/or procedure codes; the date(s) of service; and the charges.

Claims must be filed with Deseret Mutual within 60 days of the date charges for the services were incurred. Benefits are based on the plan’s provisions at the time the charges were incurred. Claims filed later than that date may be declined or reduced unless:

- (a) it is not reasonably possible to submit the claim in that time; and
- (b) the claim is submitted within one year from the date incurred.

Deseret Mutual will determine if enough information has been submitted to enable proper consideration of the claim. If not, more information may be requested from you. The Student Health Plan reserves the right to require you to seek a second medical opinion.

A request for plan benefits will be considered a claim for Plan benefits, and it will be subject to a full and fair review.

Timing of Initial Decision and Calculating Time Periods

The period within which a benefit determination is required to be made will begin at the time a claim is filed in accordance with the procedures set forth under Initial Claim above, without regard to whether all of the information necessary to make a benefit determination accompanies the filing. If a period is extended because you don't submit information necessary to decide a claim, the period for making the benefit determination will be tolled from the date the notification of the extension is sent to you until the date you respond to the request for additional information.

Claims Under the Student Health Plan

The following claims procedure will apply specifically to claims made for benefits under the plan.

Urgent Claims That Require Immediate Action

“Urgent care claims” are those claims that require notification or approval before receiving medical care, where a delay in treatment could seriously jeopardize your life or health or the ability to regain maximum function or, in the opinion of a doctor with knowledge of your health condition, could cause severe pain. In these situations:

- You will receive notice of the benefit determination (whether or not adverse) in writing or electronically as soon as possible taking into account the medical exigencies, but not later than 72 hours after Deseret Mutual receives all necessary information.
- Notice of denial may be oral with a written or electronic confirmation to follow within three days.

If you filed an urgent care claim improperly, Deseret Mutual will notify you of the improper filing and how to correct it within 24 hours after the urgent care claim was received. If additional information is needed to process the claim, Deseret Mutual will notify you of the information needed within 24 hours after the claim was received. You then have 48 hours to provide the requested information.

In determining whether a claim is urgent, Deseret Mutual will defer to your attending provider's determination. You will be notified of a determination no later than 48 hours after:

- Deseret Mutual receives the requested information; or
- The end of the 48-hour period within which you were to provide the additional information, if the information is not received within that time.

Pre-Service Claims

“Pre-service claims” require notification or approval before receiving healthcare. If your claim is a pre-service claim, and is submitted properly with all needed information, you will receive written notice of the claim decision (whether or not adverse) from Deseret Mutual within a reasonable period, but not later than 15 days following the claim is received. If you filed a pre-service claim improperly, Deseret Mutual will notify you of the improper filing and how to correct it within five days after the pre-service claim is received.

Deseret Mutual will notify you of its determination within 15 days after the claim is received, unless Deseret Mutual determines, in its discretion, that special circumstances require an extension of time for processing the claim. If an extension is required, a written or electronic extension notice indicating the special circumstances requiring the extension and the date Deseret Mutual expects to render a decision will be furnished to you before the end of the initial 15-day period. If the extension is necessary because you didn't provide missing information and you are notified of that fact, the extension will not exceed

a period of 15 days beginning as of the earlier of (i) the date the missing information is received by Deseret Mutual, or (ii) the end of a 45-day period afforded to you to provide the missing information. If all of the needed information is received within the 45-day time frame, Deseret Mutual will notify you of the determination within 15 days after the information is received. If you don't provide the needed information within the 45-day period, your claim will be denied.

If the extension is requested for reasons other than your failure to provide missing information, the extension will not exceed 15 days from the end of the initial 15-day period.

Post-Service Claims

“Post-service claims” are those claims that are filed for payment of benefits after healthcare has been received. If your post-service claim is denied, you will receive a written notice of the claim decision (whether or not adverse) from Deseret Mutual within a reasonable period, but not later than 30 days after the claim is received, as long as all required information was provided with the claim.

Deseret Mutual will notify you of its determination within 30 days after the claim is received, unless Deseret Mutual determines, in its discretion, that special circumstances require an extension of time for processing the claim. If an extension is required, a written or electronic extension notice indicating the special circumstances requiring the extension and the date Deseret Mutual expects to render a decision will be furnished to you before the end of the initial 30-day period.

If the extension is necessary because you didn't provide missing information and you are notified of that fact, the extension will not exceed a period of 15 days beginning as of the earlier of (i) the date the missing information is received by Deseret Mutual, or (ii) the end of a 45-day period afforded to you to provide the missing information. If all of the needed information is received within the 45-day time frame, Deseret Mutual will notify you of the determination within 15 days after the information is received. If you don't provide the needed information within the 45-day period, your claim will be denied.

If the extension is requested for reasons other than your failure to provide missing information, the extension will not exceed 15 days from the end of the initial 30-day period.

Special Rules for Concurrent Decisions

1. Your request to extend previously approved course of treatment

Urgent care: If an ongoing course of treatment was previously approved for a specific period or number of treatments, and a request to extend the treatment is an urgent care claim, the request will be decided by Deseret Mutual within 24 hours after the request is received, provided the request is made at least 24 hours before the end of the approved treatment. If the request for extended treatment is not made at least 24 hours before the end of the approved treatment, the request will be treated as an urgent care claim and decided according to the timeframes described on [page 34](#).

Non-urgent care: If an ongoing course of treatment was previously approved for a specific period or number of treatments, and a request to extend treatment is not an urgent care claim, the request will be considered a new claim and decided according to the post-service or pre-service timeframes described on [page 34](#), whichever applies.

2. Plan reduces or terminates a previously approved course of treatment

If an ongoing course of treatment was previously approved for a specific period or number of treatments, and the plan reduces or terminates such course of treatment (other than by plan

amendment or termination) before the end of such period or number of treatments, the reduction or termination will be considered an “adverse benefit determination” (see below) and you will be notified of the reduction or termination (sufficiently in advance of the termination or reduction to appeal the decision and get a determination upon review of the decision) before the course of treatment is reduced or terminated.

Notice of Initial Internal Adverse Benefit Determination

If your claim is wholly or partially denied, or there occurs a rescission of coverage (within the meaning of Public Health Service Act, section 2712), Deseret Mutual will provide you with written notice of the initial adverse benefit determination. The notice will set forth the following information, in a manner calculated to be understood by you, the participant:

- (a) Specific reason or reasons for the initial internal adverse benefit determination
- (b) Specific reference to those plan provisions on which the initial internal adverse benefit determination is based
- (c) Description of any additional information or material necessary to perfect the claim and an explanation of why such material or information is necessary
- (d) Appropriate information as to the steps to be taken if you wish to submit the claim for review
- (e) In the case of an initial internal adverse benefit determination by the plan:
 - If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the initial internal adverse benefit determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making the initial adverse benefit determination and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to you upon request.
 - If the initial internal adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request.
- (f) In the case of an initial internal adverse benefit determination by the plan concerning a claim involving urgent care, a description of the expedited review process applicable to such claims
- (g) Statement indicating you will be provided, upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to your claim for benefits
- (h) In the case of an initial internal adverse benefit determination by the plan as subject to the Patient Protection and Affordable Care Act (ACA):
 - You will be provided, upon request and free of charge, the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning, and the notice will contain a statement to such effect.
 - The plan must:
 - » Ensure any notice of initial internal adverse benefit determination includes information sufficient to identify the claim involved (including the date of service, healthcare provider, and claim amount (if applicable)).
 - » Ensure the reason or reasons for the initial internal adverse benefit determination includes the denial code and its corresponding meaning, as well as a description of the plan’s standard, if any, used in denying the claim.

- » Provide a description of available internal appeals and external review processes, including information about how to initiate an appeal.
- » Disclose the availability of and contact information for any applicable office of health insurance consumer assistance or ombudsman established under Section 2793 of the Public Health Service Act to help individuals with the internal claims and appeals and external review processes.
- Notices will be provided in a culturally and linguistically appropriate manner.

APPEALS OF INITIAL INTERNAL ADVERSE BENEFIT DETERMINATION

If you disagree with a claim determination after following the steps on [page 33](#), you can contact Deseret Mutual in writing to formally request an appeal. In your appeal, you may submit written comments, documents, records, and other information relating to your claim for benefits. You will be provided, upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to your claim for benefits. The review of your claims will take into account all comments, documents, records, and other information you submit, without regard to whether such information was submitted or considered in the initial benefit determination. With respect to a claim for benefits under the Student Health Plan, the plan will identify, upon request to Deseret Mutual, any medical or vocational experts whose advice was obtained on behalf of the plan in connection with your initial internal adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination.

If the appeal relates to a claim for payment, your request should include:

- Patient's name and the identification number from the ID card
- Date(s) of healthcare service(s)
- Provider's name
- Reason you believe the claim should be paid
- Any documentation or other written information to support your request for claim payment

Claims Under the Student Health Plan

The following appeals procedure will apply to claims made for benefits under the plan.

You may appeal any denial of a claim within 12 months after you receive such a denial by submitting a written request for review to Deseret Mutual.

The review of your appeal will not afford deference to the initial internal adverse benefit determination and will be conducted by an appropriate committee or named fiduciary of the plan who is neither the individual who made the initial internal adverse benefit determination that is the subject of the appeal, nor the subordinate of such individual. In deciding an appeal based in whole or in part on a medical judgment, including determinations about whether a particular treatment, drug, or other item is experimental, investigational, or not medically necessary or appropriate, the appropriate committee or named fiduciary will consult with a healthcare professional who has appropriate training and experience in the field of medicine involved in the medical judgment and who is neither an individual who was consulted in connection with the initial internal adverse benefit determination that is the subject of the appeal, nor the subordinate of any such individual.

In the case of a claim under the plan involving urgent care, you are entitled to an expedited review process in which:

- You may submit a request for an expedited appeal of an initial internal adverse benefit determination orally or in writing; and

- All necessary information, including the plan's benefit determination on review, will be given to you by telephone, fax, or other available similarly expeditious method.

Timing of Notification of Benefit Determination on Review

For purposes of this section, the period within which a benefit determination on review is required to be made will begin at the time an appeal is filed without regard to whether all the information necessary to make a benefit determination on review accompanies the filing. If a period is extended as permitted on [page 34](#) because you don't submit information necessary to decide a claim, the period for making the benefit determination on review will be tolled from the date the notification of the extension is sent to you until the date you respond to the request for additional information.

Appeal Process

A qualified committee or individual who was not involved in the decision being appealed will be appointed to decide the appeal. If your appeal is related to clinical matters, the review will be done in consultation with a healthcare professional with appropriate expertise in the field who was not involved in the prior determination. Deseret Mutual may consult with or seek the participation of medical experts as part of the appeal resolution process. You hereby consent to this referral and the sharing of pertinent health claim information. Upon request and free of charge you have the right to reasonable access to and copies of, all documents, records, and other information relevant to your claim for benefits.

Appeals Determinations

Pre-Service and Post-Service Claim Appeals

You will be provided with written or electronic notification of the decision on your appeal as follows:

For appeals of pre-service claims (see [page 34](#)), an internal appeal will be conducted and you will be notified by Deseret Mutual of the decision within a reasonable period appropriate to the medical circumstances, but not later than 15 days after receiving a request for appeal of a denied claim. If you aren't satisfied with the internal appeal decision of Deseret Mutual, you have the right to request an external review as described under *Expedited External Review Request* on [page 42](#).

For appeals of post-service claims (see [page 35](#)), the internal appeal will be conducted and you will be notified by Deseret Mutual of the decision within a reasonable period appropriate to the medical circumstances, but not later than 30 days after receiving a request for appeal of a denied claim. If you aren't satisfied with the internal appeal decision of Deseret Mutual, you have the right to request an external review as described under *Standard External Review Request* on [page 41](#).

For procedures associated with urgent care claims, see *Urgent Care Claim Appeals That Require Immediate Action*, which follows.

Please note, Deseret Mutual's decision is based only on whether or not benefits are available under the Student Health Plan for the proposed treatment or procedure. The determination as to whether the pending health service is right for you is between you and your doctor.

Urgent Care Claim Appeals That Require Immediate Action

Your appeal may require immediate action if a delay in treatment could significantly increase the risk to your health or the ability to regain maximum function or cause severe pain. In these urgent situations:

- The appeal does not need to be submitted in writing. You or your doctor should call Deseret Mutual as soon as possible. Deseret Mutual will provide you with a written or electronic determination within 72 hours after your request is received for review of the determination taking into account the seriousness of your condition.

Deseret Mutual has the exclusive right to interpret and administer the provisions of the plan. Deseret Mutual's decisions are conclusive and binding. Deseret Mutual has final claims adjudication authority under the plan.

Manner of Notification of Final Internal Benefit Determination

Deseret Mutual will provide you with written or electronic notice of a plan benefit determination on review. If it is a final internal adverse benefit determination, the notice will set forth the following information, in a manner calculated to be understood by you, the participant:

- (a) Specific reason or reasons for the final internal adverse benefit determination
- (b) Reference to the specific plan provisions on which the final internal adverse benefit determination is based
- (c) Statement that you are entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant your claim for benefits
- (d) Statement describing any voluntary appeal procedures offered by the plan and your right to get the information about such procedures
- (e) In the case of the Student Health Plan:
 - If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the final internal adverse benefit determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the final internal adverse benefit determination and that a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge to you upon request.
 - If the final internal adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request.
 - The following statement: "You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact the Idaho Department of Insurance."
- (f) Statement indicating that you will be provided, upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to your claim for benefits.
- (g) In the case of a final internal adverse benefit determination by the plan, as subject to the ACA:
 - You will be provided, upon request and free of charge, the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning, and the notice will contain a statement to such effect.
 - The plan must:
 - » Ensure any notice of initial internal adverse benefit determination includes information sufficient to identify the claim involved (including date of service, healthcare provider, and claim amount (if applicable)).

- » Ensure the reason or reasons for the final internal adverse benefit determination includes the denial code and its corresponding meaning, as well as a description of the plan's standard, if any, used in denying the claim.
 - » Provide a description of available internal appeals and external review processes, including information about how to initiate an appeal.
 - » Disclose the availability of and contact information for any applicable office of health insurance consumer assistance or ombudsman established under Section 2793 of the Public Health Service Act to help individuals with the internal claims and appeals and external review processes.
- Notices will be provided in a culturally and linguistically appropriate manner.

General Rules

Voluntary Extensions

As described beginning on [page 38](#), Deseret Mutual must decide your claim and/or appeal within certain timeframes, and Deseret Mutual may extend those timeframes in its discretion in certain circumstances. In addition, Deseret Mutual may request that you voluntarily agree to allow Deseret Mutual additional time extensions. You may allow or deny these additional “voluntary” extensions at your discretion.

Rules Generally Applicable to Claims Under the Student Health Plan

The following appeals procedure will apply to claims made for benefits under the plan as subject to the ACA and these default internal claims procedures.

- The plan must allow you to review the claim file and present evidence as part of the internal claims appeals process.
- The plan must provide you, free of charge, with any new or additional evidence considered, relied upon, or generated by the plan (or at the direction of the plan) in connection with your claim. Such evidence must be provided as soon as possible and sufficiently in advance of the date the notice of final internal adverse benefit determination is required to be provided to give you a reasonable opportunity to respond before that date.
- Before the plan can issue a final internal adverse benefit determination based on a new or additional rationale, you must be provided, free of charge, with the rationale. The rationale must be provided as soon as possible and sufficiently in advance of the date the notice of final internal adverse benefit determination is required to be provided to give you a reasonable opportunity to respond before that date.

Authorized Representatives

Any reference in these procedures to “you” or the “participant” is also a reference to your or the participant’s authorized representative making a claim on your or his/her behalf. Deseret Mutual reserves the right to establish reasonable procedures for determining whether an individual has been authorized to act on your and/or the participant’s behalf.

YOUR RIGHT TO AN INDEPENDENT EXTERNAL REVIEW

Please read this notice carefully. It describes the procedure for review of a disputed health claim by a qualified professional who has no affiliation with your health plan. If you request an independent external review of your claim, the decision made by the independent reviewer will be binding and final on the Student Health Plan Trust. Because the BYU-Idaho Student Health Plan is not subject to the Employee

Retirement Income Security Act of 1974 (ERISA), you will not have the right to further review of your claim by a court, arbitrator, mediator, or other dispute resolution entity, as more fully explained under *Binding Nature of the External Review Decision* (see [page 42](#)).

If we issue a final benefit determination of your request to provide or pay for a healthcare service or supply, you may have the right to have the decision reviewed by healthcare professionals who have no association with the Student Health Plan. You have this right only if our denial decision involved:

- The medical necessity, appropriateness, healthcare setting, level of care, or effectiveness of your healthcare service or supply, or
- Our determination that your healthcare service or supply was investigational.

You must first exhaust the internal grievance and appeal process. This includes completing all levels of appeal or, unless you requested or agreed to a delay, our failure to respond in writing to a standard appeal within 35 days or to an urgent appeal within three business days of the date you filed your appeal. The Student Health Plan may also agree to waive the exhaustion requirement for an external review request. If your request qualifies as an “urgent care request” as defined on [page 34](#).

You may submit a written request for an external review to:

Idaho Department of Insurance
 Attention: External Review
 700 W. State St., 3rd Floor
 Boise, ID 83720-0043

For more information and for an external review request form:

- See the department’s website at www.doi.idaho.gov, or
- Call the department at 208-334-4250, or toll-free in Idaho at 800-721-3272.

You may represent yourself in your request or you may name another person, including your treating healthcare provider, to act as your authorized representative. If you want someone else to represent you, you must include a signed *Appointment of an Authorized Representative* form with your request.

Your written external review request to the Department of Insurance must include a completed form authorizing the release of any of your medical records that the independent review organization may require to reach a decision on the external review. The department will not act on an external review request without your completed authorization form.

If your request qualifies for external review, the Student Health Plan’s final adverse benefit determination will be reviewed by an independent review organization selected by the department. The Student Health Plan will pay the costs of the review.

Standard External Review Request: You must file your written external review request with the department within four months after the Student Health Plan issues a final notice of denial.

1. Within seven days after the department receives your request, the department will send a copy to the Student Health Plan.
2. Within 14 days after the Student Health Plan receives your request from the department, we will review your request for eligibility. Within five business days after we complete that review, we will notify you and the department in writing if your request is eligible or if we need more information. If we deny your eligibility for review, you may appeal that determination to the department.
3. If your request is eligible for review, the department will assign an independent review organization to your review within seven days of receiving Deseret Mutual’s notice. The department will also notify you in writing.

4. Within seven days of the date you receive the department's notice of assignment to an independent review organization, you may submit any additional information in writing that you want to be considered in the review to the independent review organization.
5. The independent review organization must provide written notice of its decision to you, to us, and to the department within 42 days after receiving an external review request.

Expedited External Review Request: You may file a written "urgent care request" with the department for an expedited external review of a pre-service or concurrent service denial. You may file for an internal urgent appeal with us and for an expedited external review with the department at the same time.

Urgent care request means a claim relating to an admission, availability of care, continued stay or healthcare service for which the covered person received emergency services but has not been discharged from a facility, or any pre-service or concurrent care claim for medical care or treatment for which application of the time periods for making a regular external review determination:

1. Could seriously jeopardize the life or health of the covered person or the ability of the covered person to regain maximum function;
2. In the opinion of the treating healthcare professional with knowledge of the covered person's medical condition, would subject the covered person to severe pain that cannot be adequately managed without the disputed treatment; or
3. The treatment would be significantly less effective if not promptly initiated.

The department will send your request to us. We'll determine, no later than the second full business day, if your request is eligible for review. We will notify you and the department no later than one business day after our decision if your request is eligible. If we deny your eligibility for review, you may appeal that determination to the department.

If your request is eligible for review, the department will assign an independent review organization to your review upon receipt of our notice. The department will also notify you. The independent review organization must provide notice of its decision to you, to us, and to the department within 72 hours after the date of receipt of the external review request. The independent review organization must provide written confirmation of its decision within 48 hours of notice of its decision. If the decision reverses our denial, we will notify you and the department of our intent to pay the covered benefit as soon as reasonably practicable, but not later than one business day after receiving the decision.

Binding Nature of the External Review Decision: The external review decision by the independent review organization will be final and binding on both you and the Student Health Plan Trust. **This means that if you elect to request external review, you will be bound by the decision of the independent review organization. You will not have any further opportunity for review of our denial after the independent organization issues its final decision.** If you choose not to use the external review process, other options for resolving a disputed claim may include mediation, arbitration, or filing an action in court.

Under Idaho law, the independent review organization is immune from any claim relating to its opinion rendered, or acts or omissions performed within the scope of its duties, unless performed in bad faith or involving gross negligence.

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

Allowable Charge (Limit): The maximum dollar amount Deseret Mutual will pay for a defined procedure

Brigham Young University-Idaho: The Plan Sponsor, the Trustor and Trustees of the Brigham Young University-Idaho Student Health Plan Trust

Brigham Young University-Idaho Student Health Plan Trust: The Trust established for purposes of receiving payments, contributions, income, interest, or other monies from the Trustor and other qualified participants and purchasing medical benefits for the persons who may from time to time be beneficiaries hereunder pursuant to the terms of the BYU-Idaho Student Health Plan, which may be amended from time to time

Congenital Anomaly: A condition existing at or from birth that is a significant deviation from the common form or function of the body, whether caused by a hereditary or developmental defect or disease. “Significant deviation” means a deviation that impairs the function of the body. It includes but is not limited to cleft lip, cleft palate, webbed fingers or toes, sixth toes or fingers, or defects of metabolism and other conditions that are medically diagnosed to be congenital anomalies.

Contracted Facilities: Hospitals, labs, and other healthcare facilities that have contracted with Deseret Mutual to provide services to participants

Contracted Providers: Physicians, specialists, and other providers of healthcare 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.

Deseret Mutual Insurance Company (“Deseret Mutual”): The Plan administrator hired by the Brigham Young University – Idaho Student Health Plan and Trust to handle claims processing, pay providers, and manage other functions related to the Brigham Young University – Idaho Student Health Plan and Trust

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 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

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

Inpatient: A patient who stays in a hospital while receiving medical care

Matriculating Student: A student admitted to BYU-Idaho on one of the three regular enrollment tracks (fall-winter, winter-spring, spring-fall), or on the “fast track” enrollment option

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 healthcare facilities that have not contracted with Deseret Mutual to provide services to participants

Non-contracted Providers: Physicians, specialists, and other providers of healthcare services that have not contracted with Deseret Mutual to provide services to participants

Outpatient: A patient who receives treatment at a hospital, emergency room, or clinic, but who is not hospitalized

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

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

FREQUENTLY ASKED QUESTIONS

Why does Deseret Mutual administer the Student Health Plan?

Deseret Mutual is a not-for-profit entity. They do not pay commissions to agents or brokers to sell the plan. The Student Health Plan is a cost-effective product with minimal overhead costs to handle claims. BYU-Idaho and Deseret Mutual review the benefits and rates of the plan on a regular basis. Because of this, we believe the Student Health Plan sufficiently addresses medical costs for the vast majority of students.

Why is the waiver policy so rigid?

The waiver policy works to decrease the rates for students enrolled in the plan. Because Deseret Mutual is a not-for-profit organization, it has no incentive to enforce this policy except to benefit you. It makes sure that students are complying with BYU-Idaho's enrollment policies while providing the most cost-effective plan possible.

Why do I need a health plan?

Without adequate coverage, unexpected medical expenses could alter your future dramatically. The costs of medical care and hospitalization continue to increase at an alarming rate. An accident, unexpected illness, or hospitalization could result in a significant financial burden to you, your family, and the community.

As part of attendance at Church universities, students are required to maintain adequate health coverage. This requirement also applies to students who are off-track or serving in internships.

I'm off track. Do I still have to be enrolled in the Student Health Plan?

Yes. Enrollment in the Student Health Plan is on an annual basis. This means you must be enrolled in the plan during both on-track and off-track semesters.

I have other coverage. Can I waive the Student Health Plan?

BYU-Idaho will allow you to waive the plan if you already have an Affordable Care Act-compliant health plan that offers full medical benefits for you in Idaho and that is provided by Idaho full coverage Medicaid/Medicare or your parent's, your own, or your spouse's employer. Otherwise, you must be enrolled in the Student Health Plan.

It's my first time enrolling in the Student Health Plan. What do I need to do?

Nothing. You will be enrolled in the plan automatically when you register for classes.

I had private coverage, but I need to switch to the Student Health Plan. What should I do?

For help to enroll, contact the Student Health Center. You must provide proof of the termination of your other health plan.

What are the plan benefits?

Please see the Student Health Plan handbook online at www.dmba.com/nsc/Student/Handbooks.aspx, or you may call Deseret Mutual at 800-777-3622.

Does the plan cover specialty (or high-cost) pharmacy, dental, or eyewear costs?

No. Covering these costs would inflate plan rates and make the plan unaffordable for the vast majority of students. However, the Student Health Plan does cover one routine eye exam each plan year. Additionally, the Student Health Center pharmacy offers low-cost pharmaceuticals, including commercial generic medication, oral contraceptives, and over the counter medications. The pharmacy can also educate you about available resources for lower prices on typically high-cost drugs.

Will my waiver of coverage automatically renew?

No. You must fill out a waiver each semester to verify your coverage status when enrolling for classes.

I will be serving an internship this semester. Am I still covered by the Student Health Plan?

Yes. Even if you're away from the Rexburg area, you still have coverage. As part of attendance at Church universities, students are required to maintain adequate health coverage. This requirement also applies to students who are off-track or serving internships.

How do I make rate payments for the Student Health Plan?

Your student account will be charged. Payment is due at the same time as tuition for each semester or block. The deadline for enrollment in the Student Health Plan is at the same time. Refunds are not granted after that date.

I just got married. Do I need to let you know?

Yes, especially if you are adding your spouse to your Student Health Plan coverage. Your plan rate and benefits change when you add a dependent to your coverage. For a summary of these changes and when you need to make them, please see the Student Health Plan handbook at www.dmba.com/nsc/Student/Handbooks.aspx

Will the plan cover my wife's maternity costs?

If she is a full-time student, your wife will have maternity coverage after she meets the \$500 student deductible. If your wife is not a full-time student and is enrolled as a dependent on your plan, she is covered for all maternity charges exceeding \$5,250. (That is, she must meet the \$500 student deductible and the \$4,750 non-student spouse maternity deductible.)

I just had a baby. Is my baby automatically covered by the Student Health Plan?

No. You must contact the Student Health Plan personnel at the Student Health Center within 63 days of birth or adoption to enroll your baby.

I'm graduating but want to remain enrolled in the Student Health Plan. How do I keep my coverage?

Contact the Student Health Plan personnel at the Student Health Center to enroll in the Extended Coverage plan. You may enroll in Extended Coverage for up to four consecutive months after your last day of coverage.

I want to end my Student Health Plan coverage. What do I need to do?

If you are graduating or leaving school permanently, your coverage will end automatically. If you enroll in the Student Health Plan and then obtain other coverage that meets BYU-Idaho's requirements, you may discontinue your enrollment in the Student Health Plan at the beginning of the next semester or block. To do so, submit an online waiver at www.byui.edu/healthcenter before the beginning of the semester or block. Or you can complete a form and submit it to the Student Health Plan personnel at the Student Health Center.

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OFFERED BY: BRIGHAM YOUNG UNIVERSITY-IDAHO



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