BYUENS1SPN0725

STUDENT HEALTH PLAN 2025–2026

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I’m sick! What should I do?

A1. 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

GO TO STEP A2

A2. Get help immediately!

- Urgent care, $25 copayment
- Emergency room, $50 copayment
- $300 individual deductible (up to $600 per family) applies outside of the health centers

GO TO STEP A3

A3. After the emergency

- Call DMBA 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 health centers. See step B4 at the bottom right.

GO TO STEP A4

A4. What do I pay a provider outside of the BYU Student Health Center?

- That depends on the services you receive.
- For more information, see *Covered Services* on page 20.
- Also see step B4 to the right.

END

B1. Is it a non-emergency?

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

GO TO STEP B2

B2. Go to the BYU Student Health Center

- Call for an appointment at 801-422-5156. Your copayment is $10.
- For answers to your medical questions, go to health.byu.edu.
- If you need to be treated immediately but the health center isn’t open, go to the nearest urgent care facility or emergency room. See step A2 to the left.

GO TO STEP B3

B3. What if the health centers can’t treat me?

- The health center will refer you to an in-network provider in the community.
- $300 individual deductible (up to $600 per family) applies outside of the health centers

GO TO STEP B4

B4. What if an outside provider recommends additional care?

- Before receiving any care outside of the health centers, call DMBA to ask about preauthorization requirements.
- 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.

END

For more information, contact the Student Health Plan Office at healthplan@byu.edu or 801-422-2661.

Student Health Plan Summary of Benefits

Health centers: For your primary care provider, you and your covered dependents must use the BYU Student Health Center in Provo or the Madsen or Sugar House health centers in Salt Lake. Covered services at the health centers are paid at 100% after your copayment.** If necessary, the health center will refer you to a provider to receive additional care. Any service provided outside of the health centers will be subject to the plan deductible unless otherwise stated by the plan.

Preauthorization: To maximize benefits, call DMBA at 800-777-3622 to ask about preauthorization requirements for services received outside of health centers. Office visits generally do not require preauthorization. Services performed during an office visit (tests, labs, surgery, etc.) may require preauthorization. Providers can request preauthorization through the Provider Portal at www.dmba.com.

Copayments at health centers: $10 for regular visits and $15 for urgent care visits. **Copayments outside of health centers**: $25 per service for physician, urgent care, and other outpatient care; $50 for hospital emergency room visits; $300 per hospital admission.

Deductibles: $300 per person; $600 per family; $3,000 maternity deductible* for eligible spouse/dependent(s) plus all applicable copayments. Deductible applies to all services (except prescription drugs) received outside health centers.

Maximum benefit: $20,000 per person per academic year for services received outside of the health centers. For coverage of medical expenses above the maximum benefit, see *Large Claims Coverage* on page 31.

Explanation of covered expenses: Plan payments are subject to allowable limits, determined by DMBA.

COVERED SERVICES	IN-NETWORK PROVIDER	OUT-OF-NETWORK PROVIDER
Ambulance: Licensed land or air transport	80% of allowable limit after copayment	
Ambulatory surgical center: Outpatient surgery, services, and supplies	80% of allowable limit after copayment	50% of allowable limit after copayment
Diagnostic X-ray and lab services: CT, MRI, ultrasound, lab, and pathology	80% of allowable limit after copayment	50% of allowable limit after copayment
Emergency care: Emergency room services and supplies	80% of allowable limit after copayment	
Home healthcare: Services and supplies from a home health agency	80% of allowable limit after copayment	50% of allowable limit after copayment
Hospital medical services: Room, surgical services and supplies, outpatient medical	80% of allowable limit after copayment	50% of allowable limit after copayment
Maternity care (covered dependents subject to $3,000 deductible)* • Hospital and ancillary services • Physician office visits	• 80% of allowable limit after copayment • 80% of allowable limit after $25 copayment per visit to a maximum of $250 for routine care	• 50% of allowable limit after copayment • 50% of allowable limit after $25 copayment per visit to a maximum of $250 for routine care
Medical equipment (durable): Rental or purchase of eligible equipment	80% of allowable limit after copayment	50% of allowable limit after copayment
Outpatient therapy: Radiation therapy, chemotherapy, dialysis, physical therapy	80% of allowable limit after copayment	50% of allowable limit after copayment
Physician medical services: Office visits, hospital visits, surgeon, surgical assistant, and anesthesiologist	80% of allowable limit after copayment	50% of allowable limit after copayment
Prescription drugs (high-cost and specialty drugs are excluded)	Covered drugs: • 80% at the health centers or Harmons City Creek pharmacies • 60% at in-network retail pharmacy • No coverage at out-of-network pharmacy	Non-covered drugs: • No coverage at any pharmacy

* Maternity coverage is included for all student contract holders with no additional deductible. An eligible spouse or dependent must meet an additional $3,000 deductible before the plan pays for maternity care. This summary of benefits provides a brief review of plan benefits. For complete details of coverage, including limitations and exclusions, please read this entire handbook.

** The health centers send nearly all lab tests to an outside provider. Until you meet your deductible, you are billed 100% for these services. After that, services are covered at 80%.

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Who to Contact

SCHOOLS

Brigham Young University
Student Health Center
1750 N. Wymount Terrace Drive
Provo, UT 84604-8600

8 a.m. to 5 p.m., Monday through Friday
Telephone: 801-422-2661 • Fax: 801-422-0764
Email: healthplan@byu.edu

Ensign College
95 N. 300 West
2nd Floor
Salt Lake City, UT 84101

8 a.m. to 5 p.m., Monday and Friday
Telephone: 801-524-8143
Email: cashier@ensign.edu

HEALTH CENTERS

BYU Student Health Center
1750 N. Wymount Terrace Dr.
Provo, UT 84604
(East of MTC)

Online Appointment Scheduling health.byu.edu

Appointment Scheduling 801-422-5156
8 a.m. to 5:30 p.m., Monday to Friday

Urgent Care 801-422-5128
8 a.m. to 5:30 p.m., Monday to Friday
Fall and winter semesters: 8 to 11:30 a.m. on Saturday

Oak Hills Pharmacy at BYU Student Health Center 801-422-5171
9 a.m. to 6 p.m., Monday to Friday (except on holidays)

Madsen Health Center
555 Foothill Drive
Salt Lake City, UT 84112
(Corner of Foothill Drive and Wasatch Drive)
Telephone: 801-581-8000

Sugar House Health Center
1280 E. Stringham Ave.
Salt Lake City, UT 84106
Telephone: 801-581-2000

Harmons City Creek Pharmacy
135 East 100 South
Salt Lake City, UT 84111
Telephone: 801-428-0366

Navitus Health Solutions
833-354-2226

DMBA

Preauthorization, Claims Payment, and Benefit Questions
Toll free 800-777-3622
Salt Lake City area 801-578-5600
150 Social Hall Ave. Suite 170, P.O. Box 45530, Salt Lake City, UT 84145

DMBA's Preferred Provider Network

Find an in-network provider:
Utah and Southeast Idaho: DMBA Network Providers
800-777-3622 or www.dmba.com

All other states: UnitedHealthcare Options PPO
866-633-2446 or www.myuhc.com

Hawaii: MDX
808-675-4873

Access the Student Health Plan handbook: www.dmba.com/nsc/Student/Handbooks.aspx

To contact DMBA online, go to: www.dmba.com/sc/dmba/SecureMessage.aspx

The Student Health Plan is exempt from regulation as insurance by order of the Utah Department of Insurance. See *In re: BYU Student Health Plan, No. 2003-050-AD* (November 21, 2003).

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After-hours Emergencies

UTAH COUNTY URGENT CARE FACILITIES	SALT LAKE COUNTY URGENT CARE FACILITIES
American Fork InstaCare 801-492-2550 98 N. 1100 E., Suite 101, American Fork	Intermountain Alta View InstaCare 801-501-2110 9450 S. 1300 E., Sandy
Blue Rock Medical 801-375-2177 3152 N. University Ave., Suite 120, Provo	Intermountain Cottonwood InstaCare 801-314-7700 181 E. Medical Tower Drive, Murray
Lehi InstaCare 801-753-4310 3429 N. 1200 W., Lehi	Intermountain Draper InstaCare 801-495-7970 12473 S. Minuteman Dr., Draper
Intermountain Highland Clinic 801-763-2900 10968 N. Alpine Highway, Highland	Intermountain Holladay InstaCare 801-871-6400 6272 S. Highland Drive, Suite 103 Murray
Intermountain North Orem InstaCare 801-714-5500 1975 N. State St., Orem	Intermountain Southridge InstaCare 801-285-4560 3723 W. 12600 S., Suite 150, Riverton
Intermountain Saratoga Springs InstaCare 801-714-5585 354 W. Crossroads Blvd., Saratoga Springs	Intermountain Taylorsville InstaCare 801-840-2020 3845 W. 4700 S., Taylorsville
Intermountain Spanish Fork InstaCare 385-344-6600 819 E. Market Place Dr., Spanish Fork	Intermountain West Jordan InstaCare 801-256-6399 2655 W. 9000 S., West Jordan
Intermountain Utah Valley InstaCare 801-357-1770 395 W. Cougar Blvd., Suite 205, Provo	
Parkway Urgent Care 801-234-8600 145 W. University Pkwy., Orem	

UTAH COUNTY HOSPITALS	SALT LAKE COUNTY HOSPITALS
Holy Cross Hospital Mountain Point 385-345-3000 3000 N. Triumph Blvd., Lehi	Holy Cross Hospital Jordan Valley 801-561-8888 3580 W. 9000 South, West Jordan
Intermountain Health American Fork 801-357-8310 170 N. 1100 East, American Fork	Holy Cross Hospital Salt Lake 801-350-4111 1050 E. South Temple, Salt Lake City
Intermountain Health Orem Community 801-224-4080 331 N. 400 West, Orem	Holy Cross Hospital West Valley 801-964-3100 3460 S. Pioneer Parkway, West Valley City
Intermountain Health Spanish Fork 385-344-5000 765 E. Market Place Dr., Spanish Fork	Intermountain Health Alta View 801-501-2600 9660 S. 1300 East, Sandy
Intermountain Health Utah Valley 801-357-7850 1034 N. 500 West, Provo	Intermountain Health Medical Center 801-507-7000 5121 S. Cottonwood St., Murray
Mountain View Hospital 801-465-7104 1000 E. 100 North, Payson	Intermountain Health Riverton 801-285-4000 3741 W. 12600 S., Riverton
Primary Children’s Hospital Lehi Campus 800-662-1000 2250 N. Miller Campus Dr., Lehi	LDS Hospital 801-408-1100 8th Avenue and “C” St., Salt Lake City
Timpanogos Regional Hospital 801-797-5337 750 W. 800 North, Orem	Lone Peak Hospital 801-545-8000 11925 S. State St., Draper
	Primary Children’s Hospital 801-432-2600 100 N. Mario Capecchi Drive, Salt Lake City
	St. Mark’s Hospital 801-268-7111 1200 E. 3900 South, Salt Lake City
	University of Utah Hospital 801-581-2121 50 N. Medical Dr., Salt Lake City

Contents

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To All Students

5.1

Importance of Medical Coverage

All 3/4-time students are required to have adequate medical coverage. Your good health is essential to achieving your educational goals, and access to adequate healthcare and medical coverage is essential to your good health. Without adequate coverage, unexpected medical expenses could alter your future dramatically.

Enrollment in the Student Health Plan satisfies this coverage requirement, as does enrollment in a group medical plan provided by your employer or your spouse's or parent's employer. We work diligently to keep premiums low while maintaining appropriate benefits.

5.2

Comparing Health Plans

Medical plans vary in the coverage they offer. Some plans may provide adequate coverage while you're at home, but won't cover you while you're at school, studying abroad, traveling, or on leave of absence. Other plans may seem like a bargain up front, but leave you without access to mental health services, or with bills you can't afford. Plans that have high annual deductibles can create a financial barrier to healthcare access because your out-of-pocket expenses are so high at the time you receive services. We hope this information about our medical coverage requirements and the Student Health Plan will provide clear answers to your questions, help you evaluate your coverage options, and help you make the best choice for your coverage.

5.3

Medical Coverage Requirement

If you are a continuing student who is enrolled at least 3/4 time, you must have insurance coverage the entire time you're a continuing student, including during any summers you take off or other short-term breaks from classes.

To satisfy the health coverage requirement, you have several options:

1. Enroll in the Student Health Plan.
2. Be enrolled in a group health plan provided by your parent's, your own, or your spouse's employer that covers you in Utah.
3. Purchase an individual Affordable Care Act (ACA) compliant health plan.

If you choose any medical plan other than the Student Health Plan, you must provide verification of adequate coverage at the beginning of every academic year (each fall semester) that you are at least a ¾-time student. Carefully review any medical plan you're considering, making sure it will provide you with sufficient coverage for your current and future healthcare needs. **Coverage must be effective by the first day of the semester/term**. The Student Health Plan office (located at the BYU Student

Health Center and the Ensign College cashier's office) makes all determinations about health coverage waivers. Decisions by the Student Health Plan Office are final.

BYU requires all ELC students and F-1 and J-1 visa students to be enrolled in the BYU Student Health Plan or an ACA-compliant plan offered by a United States-based insurance company. This plan must provide comprehensive medical coverage for you while you are on campus. Insurance plans from companies outside of the United States will not be accepted.

All students enrolled at least 3/4 time (nine credit hours per semester or 4.5 credit hours per term) and all F-1 and J-1 visa students who don't submit proof of other coverage before the deadline each year will be enrolled automatically for individual coverage and assessed the appropriate premium (single or married rate) for the Student Health Plan. Students who are actively working toward a degree and have at least 0.5 on-campus credits are eligible to enroll in the Student Health Plan. Students registered for between 0.5 and nine semester or 4.5 term on-campus credits will not be automatically enrolled in the Student Health Plan, but they can enroll by contacting the Student Health Plan Office either in person or via email to healthplan@byu.edu. Graduate students who have a least nine credits during fall semester and were enrolled in the Student Health Plan for the previous summer term will automatically be enrolled for fall semester in the same plan they had during summer term.

Spouses and dependents won't be enrolled automatically the first semester or term you're on the plan. If you want coverage for your spouse and dependents, you must enroll them in the plan during open enrollment of the first semester or term you are attending.

5.4

Annual Enrollment Requirement

The Student Health Plan has an annual enrollment requirement. This means when you enroll, you enroll for the entire academic year. If you gain new health coverage, you may waive the Student Health Plan. (For information about how to waive enrollment, see *Changing Enrollment* on page 13.)

If you don't enroll for classes for one semester but intend to return for the following semester, you must maintain your enrollment in the Student Health Plan.

For more information about enrollment in the plan and its various coverage options, please see the *Enrollment* section on page 12.

5.5

Health Coverage Identification Card

You can access your Student Health Plan ID card online at www.dmba.com. On the homepage select *View ID Card* and follow instructions. If you have difficulty accessing your card or need assistance in requesting another card, call DMBA at 800-777-3622.

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How the Plan Works

Medical care covered by this plan is provided by or coordinated through the health centers. If you need eligible services the health centers can't provide, you'll be referred to providers in the community who are part of DMBA's preferred provider network. These providers have contracted with DMBA to offer care at a reduced cost to participants. The discounts will be reflected in the portion of charges you're responsible to pay. If you live in Utah County, you must use the BYU Student Health Center for your initial care. **The BYU Student Health Center is your primary care provider**.

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

Plan benefits will not be paid for services received outside of the health centers until you meet your annual deductible of $300 per person, up to $600 per family. Also, eligible spouse/dependent(s) must meet an additional $3,000 deductible for maternity expenses. This means if a spouse is not the contract holder, she is responsible for the first $3,000 of the cost for prenatal care and baby delivery. Regular plan benefits apply to eligible expenses over $3,000.

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

If you receive services outside of the health centers, you or your provider must submit an itemized bill to DMBA. DMBA will process your claim, send a check for the plan benefit to the 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 provider.

In some cases, the provider will bill more than DMBA's **allowable limit** for the services you received. If so, your *Explanation of Benefits* will also itemize how much of the bill is **over the allowable limit**.

- If you receive services from **in-network providers**, you don't have to pay any amount over the allowable limit. When providers contract with DMBA, they agree not to bill you for more than the allowable limit.
- If you receive services from an **out-of-network provider**, you are responsible to pay any charges over the allowable limit.

You are also responsible to pay your provider for any services that aren't covered by the plan. For more definitions of terms, see *Definitions* on page 42.

For example, if you visit an in-network urgent care outside of the health centers to treat a broken bone, you will pay:

- Your copayment
- Your deductible: 100% of costs up to $300 (or up to $600 on a family plan)
- Your responsibility: after you meet your deductible, this is 20% of costs up to your plan maximum (see *Large Claims Coverage* on page 31)

6.1

Preauthorization

For services received outside of the health centers, you may need to obtain preauthorization from DMBA before you receive the services. You or your provider can ask about services that need preauthorization by calling DMBA at 800-777-3622 before receiving care.

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

To preauthorize, please have your physician complete the online *Provider Preauthorization Request* form at www.dmba.com.

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

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

If your provider recommends care that is not specified in the initial preauthorization (such as a test at another facility or consultation with another healthcare provider), your provider must contact DMBA for preauthorization before you receive the additional care. Remember, care beyond the scope of the original preauthorization must also be authorized in advance by DMBA.

Even if you have preauthorization from DMBA, that does not guarantee payment for any treatment you may receive. The guidelines, benefits, and exclusions of the plan will determine claims payment.

6.2

Copayments

For clinician, X-ray, and laboratory services you receive at the health centers, your copayments are:

- $10 for regular clinic visits
- $15 for walk-in urgent care visits
- If you miss your appointment or fail to cancel one hour beforehand, you will be charged $10 for medical appointments, $30 for mental health appointments, and $50 for counseling appointments
- The health centers send nearly all lab tests to an outside provider. Until you meet your deductible, you are billed 100% for these services. After that, services are covered at 80%.

For authorized services you receive outside of the health centers, your copayments are:

- $25 per service for physician services and other outpatient care
- $50 for hospital emergency room visits
- $300 per hospital admission ($100 for newborn infants)

6.3

Plan Benefits and Participant Responsibility

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

	SERVICES AT THE HEALTH CENTERS	SERVICES OUTSIDE OF THE HEALTH CENTERS
The plan pays:	100% (80% for lab tests sent to outside providers)	In-network providers: 80% Out-of-network providers: 50%
You pay:	0%	In-network providers: 20% Out-of-network providers: 50%

Remember, benefits for services received outside of the health centers are based on the lesser of billed charges, contracted rates, or allowable limits for the services received, as determined by DMBA. For all services, the guidelines, benefits, and exclusions of the plan will determine claims payment.

The maximum benefit for all services received outside of the health centers is $20,000 per person per academic year. For expenses that exceed the plan maximum, please see *Large Claims Coverage* on page 31.

6.4

Deductible

There is a $300 annual deductible per person (up to $600 per family) for services received outside of the health centers. This means that every academic year you must pay the first $300 (or first $600 per family) of eligible medical expenses before you begin to receive plan benefits.

SERVICES AT THE HEALTH CENTERS	SERVICES OUTSIDE OF THE HEALTH CENTERS	
Deductible does not apply	Pharmacy	Deductible does not apply
	Eligible services	$300 individual deductible (up to $600 per family)
	Spouse/dependent(s) maternity expenses	Additional $3,000 deductible per pregnancy

All deductibles run concurrent with the academic year. This means you will only need to meet the deductible once in an academic year.

Charges for services received by in-network providers are subject to allowable limits before they are applied to your deductible.

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Eligibility

The following individuals are eligible to enroll in the Student Health Plan, but must be enrolled the first semester of the academic year you attend or when you have a qualifying event:

Students who are actively working toward a degree and have at least 0.5 on-campus credits are eligible to enroll in the Student Health Plan. Students registered for between 0.5 and nine semester or 4.5 term on-campus credits will not be automatically enrolled in the Student Health Plan, but they can enroll by contacting the Student Health Plan Office in person, by phone at 801-422-2661, or by email to healthplan@byu.edu.

Dependents: If you enroll in the Student Health 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 your legal wife.
- Your eligible children. Eligible children are your children who are younger than 26 including:
  - Natural children (including infants from the 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 the custody of your spouse, 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 whom you're the legal guardian. If you add a newly adopted baby to your plan, the baby will be covered from the date you sign the adoption papers. (In Utah, this can't happen before 24 hours plus one minute after the birth mother has signed relinquishment papers.) For adopted babies, the congenital anomalies exclusion doesn't apply.
- Your unmarried child who is 26 or older and incapable of self-support because of mental or physical incapacity that existed 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.

8

Enrollment

8.1

Enrolling Yourself

You may enroll in the Student Health Plan, either for individual or family coverage, at the beginning of your first semester or term as a continuing student. When you enroll in the Student Health Plan, you enroll for the entire academic year.

Open Enrollment: Your enrollment is due on or before the add/drop deadline for the first semester or term you enroll in classes at least 3/4 time. Your enrollment will remain in effect until the end of the academic year (see *Coverage Periods* on page 16).

At the beginning of each academic year (fall semester) you'll be enrolled automatically in the same coverage option you had the previous year if you're enrolled for at least 3/4 time. If you wish to make any changes (add or remove dependents) to this coverage option, you must make them within the first week of fall semester. If you aren't enrolled for at least 3/4 time in the fall semester and you want Student Health Plan coverage, you must contact the appropriate office by the last day to add or drop classes (Student Health Plan office at BYU or cashier's office at Ensign College).

Late Enrollment: If you don't enroll before the first day of classes, you have a late enrollment "grace period." This will end one week after classes begin for a semester or term. **No enrollments will be accepted after the end of the late enrollment period unless you meet one of the special circumstances outlined in *Changing Enrollment* on page 13**.

The enrollment deadlines are specified in *Important Dates* on page 40.

Please note, all continuing students enrolled 3/4 time or more who don't enroll in the Student Health Plan or provide verification of other coverage that meets school requirements will be enrolled in the Student Health Plan automatically for individual coverage and will be assessed the appropriate premium.

8.2

Marital Status Changes

When you get married, you are required to change your marital status from single to married. You can do this by logging in to MyBYU, clicking on the *Communications* tab, and then clicking on the *Personal Information* tab. Or you can change your status at the appropriate office (ASB records office or registration office at Ensign College). You will be charged the appropriate married student premium for the semester/term the marriage occurs.

8.3

Enrolling Your Dependents (Spouse, Children)

If you want to cover your eligible dependents, you may change your enrollment from individual coverage to family coverage at the beginning of your first semester or term, or at the beginning of each academic year (fall semester) thereafter. This must be done by the add/drop deadline.

If you enroll your family, their enrollment will generally remain in effect until the end of your enrollment in school (see *Coverage Periods* on page 16). Spouses and dependents won't be enrolled automatically the first semester or term you're on the plan. However, we'll renew enrollment for your family at the beginning of each subsequent academic year, based on their enrollment for the previous term and your current status as a 3/4-time student. Remember to notify the health center if you need to change your family's enrollment.

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

8.4

Changing Enrollment

If you acquire a new dependent because of marriage or the birth or adoption of a child, you may change your enrollment to include coverage for your new spouse and/or the new dependent as long as you apply within 60 days of this event. If this changes your coverage option, you'll be assessed the appropriate premium retroactive to the beginning of the coverage period. (Please remember, you must formally enroll your newborn child in the Student Health Plan by sending an email to healthplan@byu.edu; it isn't done for you automatically when the child is born.)

If you waive enrollment in the Student Health Plan for yourself and/or your dependents because you have other coverage that meets school requirements and you subsequently lose eligibility to continue the other coverage, you may enroll in the Student Health Plan for yourself at the block, semester, or term because of the university's medical coverage requirement. If you don't enroll your dependents within 60 days of losing eligibility for the other coverage, you must wait until the beginning of the next academic year (fall semester) to enroll them.

If you enroll in the Student Health Plan and subsequently obtain other coverage that meets school requirements, you may discontinue your enrollment in the Student Health Plan. You must notify the Student Health Plan office within 60 days of obtaining new health coverage. You can do this by logging in to MyBYU, clicking on *My Financial Center*, then choose the Health Coverage icon. Or you

can change your status at the appropriate office by submitting certification of the other coverage before the beginning of the block, semester, or term (Student Health Plan office at BYU or cashier's office at Ensign College). Your new coverage must be effective by the first day of class.

8.5

During Mission Service

If you leave school to serve a mission, you won't be covered by the Student Health Plan during your mission. Please notify the appropriate office (Student Health Plan office at BYU or cashier's office at Ensign College). You may re-enroll when you return to school. Please note, you must file a mission deferment with BYU.

8.6

After Leaving School

You can maintain your Student Health Plan coverage when not on campus, within certain limitations. If you drop your classes before the second block begins and you're a new student or haven't attended school the previous semester/term, your coverage will end. If this occurs, you'll be charged private rates for services incurred in the health centers. Please see *Away-from-Campus Coverage Option* on page 14.

9

Coverage Options

The Student Health Plan includes two coverage options. You'll be enrolled in the appropriate option based on your student status.

IF YOU ARE ...	YOUR COVERAGE OPTION IS ...
Enrolled in classes on campus with at least 0.5 credit hours	Regular on-campus coverage
Enrolled in a Study Abroad Program, an internship required for your degree, or on tour as part of a school performance group	Away-from-Campus Coverage (see below)
Admitted as a full-time student but taking a semester or term off	Away-from-Campus Coverage (see below)

The benefits for services received outside of the health centers are the same for all coverage options.

9.1

Away-from-Campus Coverage Option

If you enroll in the Student Health Plan for the academic year and then decide to take a semester or term off by not enrolling in classes but you don't lose your status as a continuing student, you'll be covered by the Student Health Plan during that semester or term. (At Ensign College, you must pay your premium by the first day of class to maintain continuing student status under the Student Health Plan if you're not enrolled in any classes.)

If you're enrolled in the Student Health Plan and you participate in a Study Abroad Program, an internship required by your department, or you travel as a member of a school performing group on tour, you'll be covered by the Student Health Plan during that semester or term.

If you have enrolled your dependents in the plan for the year, they'll be covered by this option while you are. You may make changes to your enrollment (add dependents, discontinue coverage, etc.) only as outlined under *Changing Enrollment* on page 13. Any dependents enrolled in the plan for the academic year will also be covered by this option.

While you're enrolled in this option, you must receive services at one of the health centers if you're in the area. Otherwise, you may receive services from any qualified, appropriately licensed provider. However, it is to your advantage to use providers who are part of DMBA's preferred provider network whenever possible.

You may need to obtain preauthorization from DMBA before you receive the services. You or your provider can ask about services that need preauthorization by calling DMBA at 800-777-3622 before receiving care.

9.2

Extended Coverage Option

Your Student Health Plan coverage terminates at the end of the semester/term that you graduate or lose your status as a continuing student for reasons such as suspension or transferring to another school. (Please see *Important Dates* on page 40 for the dates coverage ends.)

If you were enrolled in the Student Health Plan during your last semester or term in school and you would like to continue your coverage after you leave school, you may enroll in Extended Coverage for up to four (4) consecutive calendar months.

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

If adding a new dependent changes your coverage option and premium, the additional premium for the month the dependent became eligible must be included with the enrollment form.

Extended Coverage plans are eligible for *Large Claims Coverage* (see page 31).

Enrollment in Extended Coverage takes place on a month-by-month basis. You may enroll for up to four (4) consecutive calendar months.

To enroll, request the Extended Coverage enrollment form by email to healthplan@byu.edu. Then complete the form and submit it by email to healthplan@byu.edu or deliver it to the appropriate office (Student Health Plan office at BYU or cashier's office at Ensign College) within 60 days from the last day of coverage on the Student Health Plan. Also, you must pay your premium for your first month of coverage and pay your premium monthly thereafter.

To renew your coverage from month to month, submit your enrollment form and premium payment to the appropriate office before the end of the month that you require coverage (Student Health Plan office at BYU or cashier's office at Ensign College). Renewal applications that aren't submitted before the end of the applicable month will not be accepted. It is very important for you to meet these deadlines. Failure to renew your coverage in time will result in the end of your Extended Coverage, after which you will not be eligible to re-enroll. While you're enrolled in this option, you may receive

services from any qualified, appropriately licensed provider. However, it is to your advantage to use providers who are part of DMBA's preferred provider network whenever possible. If you're in the area, you can be seen at one of the health centers.

You may need to obtain preauthorization from DMBA before you receive the services. You or your provider can ask about services that need preauthorization by calling DMBA at 800-777-3622 before receiving care.

10

Coverage Periods

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

When you enroll in the Student Health Plan, you enroll for an entire academic year. The coverage option you choose (either individual or family coverage) will generally remain in effect until the end of the academic year, unless you graduate, lose your continuing student status, or have a qualifying event.

Please see *Important Dates* on page 40 for the exact dates coverage begins and ends for the 2025-2026 academic year.

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/term	12:01 a.m. on the date of the qualifying event
Midyear Enrollment	First day of classes for the semester/term you enroll	

WHEN DOES COVERAGE END?	AFTER YOU GRADUATE OR LOSE CONTINUING STUDENT STATUS	AFTER YOUR DEPENDENT LOSES ELIGIBILITY	AFTER YOU MOVE TO OTHER AVAILABLE COVERAGE
Regular on-campus or Away-from-Campus coverage	End of last semester/term in school	End of semester/term that dependent becomes ineligible	Beginning of next semester/term

11

Certificate of Creditable Coverage

After your coverage ends, for a *Certificate of Creditable Coverage*, call DMBA at 800-777-3622 or log into your DMBA portal and print out the certificate. This is a document certifying the length of time you were covered by the Student Health Plan.

12

Coverage at Another Church School

If you receive services at the health center of another Church school, the services will be covered as if you had received services at one of the local health centers. However, you may have to pay that school's health center for the total bill at the time of service and submit the claim provided by the health center to DMBA for reimbursement. You won't need preauthorization.

13

Premiums per Month

Premiums are due by the first day of the month. If you don't pay premiums by the first day of the month, holds can be placed on your financial account.

If you qualify to change enrollment midyear, the premium (or additional premium, if necessary) will be due immediately when you enroll for the semester or term the enrollment change becomes effective.

The premiums listed below are per month. Because this plan covers students at multiple schools, your school will collect premiums for the semester or term that you are enrolled. The total amount may vary according to the length of the semester or term. For more information, contact your school (see *Who to Contact* on page 4).

	REGULAR ON-CAMPUS AND AWAY-FROM-CAMPUS COVERAGE	EXTENDED COVERAGE
Single Student Only	$ 108 per month	$ 216 per month
Single Student with Dependent(s)	$ 399 per month	$ 594 per month
Married Student Only	$ 172 per month	$ 344 per month
Married Student with Dependent(s)	$ 602 per month	$ 906 per month

14

Discounted Dental, Eye, and Other Services

Student Health Plan participants can use this program to save money on dental services and other non-covered goods and services. While this service isn't covered by the Student Health Plan, it gives participants the ability to purchase services directly from providers at discounted prices. For more information, go to www.basixstudent.com/byu2. The program provides savings of up to 50% on the following services:

- Chiropractic services
- Dental services
- Eyeglasses, contact lenses, and sunglasses
- Health club memberships
- LASIK vision enhancement surgery

14.1

Discounted Dental Program

The Discounted Dental Program has contracted with dentists and dental specialists to provide services to students and dependents covered by the Student Health Plan at a reduced fee schedule. Again, this isn't a benefit covered by the plan. You'll be responsible to pay the dentist for the services you receive at the time of your visit. However, by using the program, you'll pay 10 to 50% less than you would have paid otherwise. To use the Discount Dental part of the program, follow the instructions below:

1. Schedule an appointment with one of the in-network providers listed on the internet at www.basixstudent.com/byu2. Be sure to tell the office you're part of the Student Health Plan's Discounted Dental Program when you make the appointment.
2. Take your Student Health Plan identification card to the appointment. If you don't have a card, call 800-777-3622 to request a card and to receive your identification number.
3. Pay the dentist for the services you receive at the time of service. The exact amount you owe will depend on the services you receive. The prices for nearly all common services are listed at www.basixstudent.com/byu2. Services not on the price list are 80% of the dentist's usual charge. You may want to print out the price list and take it with you to the dentist's office.

Because this program isn't insurance, there aren't any claim forms, enrollment procedures, benefit limitations, or conditions, etc. You and the dentist determine what services you'll receive, and you pay the dentist for those services at the time of your visit.

If you were in treatment with an in-network provider before the time you had access to the Discounted Dental Program, you'll pay the regular price. The discounted price is only applicable for services received after you had access to the program.

You must pay for services at the time you receive them. The in-network dentist is under no obligation to accept the discounted fees for services not paid for at the time of service.

Neither the school nor any of its contractors or agents have any liability for the services and/or products delivered by in-network providers. This program isn't provided by or affiliated with DMBA in any way.

Coupons, specials, and other types of offers promoted by in-network providers may only be used in conjunction with this program at the discretion of the in-network provider.

14.2

Other Discounted Services

The other discounted services include chiropractic services, eyeglasses, contact lenses, sunglasses, health memberships, and LASIK vision enhancement surgery.

To learn about the various services available and to review the list of participating providers, go to www.basixstudent.com/byu2. When using any of the discounted services, simply present your Student Health Plan identification card provided by DMBA to receive the special pricing. Payment is due at the time of service.

15

Health Centers

15.1

Locations and Operating Hours

UTAH COUNTY	SALT LAKE COUNTY	
Student Health Center (East of MTC) 1750 N. Wymount Terrace Dr. Provo, UT 84602 Telephone: 801-422-5156 Regular hours: 8 a.m. to 5:30 p.m., Monday through Friday Walk-in urgent care hours: 8 a.m. to 5:30 p.m., Monday through Friday Fall and winter semesters: 8 to 11:30 a.m. on Saturday	**Madsen Health Center** 555 Foothill Drive Salt Lake City, UT 84112 Telephone: 801-581-8000 Appointment hours: 7 a.m. to 7:30 p.m., Monday through Thursday; 7 a.m. to 5:30 p.m. on Friday; Closed Saturday and Sunday	**Sugar House Health Center** 1280 E. Stringham Ave. Salt Lake City, UT 84106 Telephone: 801-581-2000 Appointment hours: 7 a.m. to 8:30 p.m. on Monday to Friday; 8 a.m. to 8:30 p.m. on Saturday and Sunday

15.2

Available Services

The health centers have staffs of clinicians and specialists who provide services in the areas listed in the table below. Please keep in mind some of these specialties are scheduled on a part-time basis and may not always be available. Services provided at the health centers do not require preauthorization.

The pharmacy at the BYU Student Health Center is committed to providing prescription drugs to students at the lowest cost possible. If you have questions about help for high-cost prescription drugs, please discuss them with your clinician.

The Student Health Plan doesn't cover knee and ankle braces used solely for sports, but they are covered when used for injuries. If you obtain reusable medical equipment (such as crutches) from the BYU Student Health Center, you must return it. If you don't, you'll be charged a fee to cover the cost of the item.

Routine physical exams, most adult immunizations, and high-cost injections aren't covered by the Student Health Plan, but they're available at the BYU Student Health Center for a discounted fee. Cosmetic mole removal isn't covered by the Student Health Plan, nor is it available at the BYU Student Health Center.

The health centers are not Medicaid or Medicare providers.

SERVICES AVAILABLE AT THE BYU STUDENT HEALTH CENTER		
Contraception counseling	Immunization counseling	Physical therapy*
Dermatology*	Medical equipment and supplies	Podiatry
Diagnostic X-ray and lab services*	Mental health	Primary Care*
Ear, nose, and throat	Nutrition counseling*	Premarital classes
Eating disorders	Orthopedics	Sports medicine
Family medicine*	Pediatrics*	Substance abuse
Gynecology*	Pharmacy	Urgent care

* Services also provided at the Madsen and Sugarhouse clinics.

16

Services Outside of the Health Centers

The Student Health Plan covers hospitalization and many other specialized medical services the health centers don't provide. If you need such services, you will be referred to a provider in the community.

Office visits outside of the health centers generally do not require a preauthorization. Services performed during an office visit (such as tests, labs, surgery, etc.) may require preauthorization. You or your provider can ask about services that need preauthorization by calling DMBA at 800-777-3622 before receiving care.

Benefits are paid after you meet the annual deductible ($300 per person, up to $600 per family). Not all services are covered by the plan. To see which services are not covered, carefully read the exclusions.

17

Covered Services

For information about the benefits payable for services outside of the health centers, see *Plan Benefits and Participant Responsibility* on page 10. If you have questions about benefits or preauthorization requirements for a service, call DMBA at 800-777-3622. The following pages list examples of services the plan covers outside of the health centers.

17.1

Allergy services

- In-network provider: The plan pays 80% after your $25 copayment; you pay 20%.
- Out-of-network provider: The plan pays 50% after your $25 copayment; you pay 50%.
- **You must preauthorize.**

17.2

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%.

17.3

Anesthesia

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

17.4

Cardiovascular services

- In-network provider: The plan pays 80% after your $25 copayment; you pay 20%.
- Out-of-network provider: The plan pays 50% after your $25 copayment; you pay 50%.
- **You must preauthorize.**

17.5

Chemotherapy

- In-network provider: The plan pays 80%; you pay 20%.
- Out-of-network provider: The plan pays 50%; you pay 50%.
- **You must preauthorize.**

17.6

COVID vaccine

- In-network providers (including BYU Student Health Center): The plan pays 100%; you pay 0%.
- All other providers: The plan pays 50%; you pay 50%.
- For more information about getting your COVID vaccine, call the BYU Student Health Center.

17.7

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 facial injury) that occurs while you're covered by the plan.
- Benefits apply only to services received while you're covered by the plan and within two years of the accident.
- Deductible does not apply.
- **You must preauthorize.**

17.8

Diabetes education

- In-network provider: The plan pays 80% after your $25 copayment; you pay 20%.
- Out-of-network provider: The plan pays 50% after your $25 copayment; you pay 50%.
- The maximum benefit is $300 per academic year.
- **You must preauthorize**.

17.9

Diabetic supplies

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

17.10

Dialysis

- In-network provider: The plan pays 80%; you pay 20%.
- Out-of-network provider: The plan pays 50%; you pay 50%.
- **You must preauthorize.**

17.11

Emergency room

- If care at an urgent care facility is appropriate, it is a less expensive alternative.
- The plan pays 80% after your $50 copayment; you pay 20%.
- You don't need to authorize the initial visit but **must preauthorize any follow-up care with DMBA.**

17.12

Eye exams

- In-network provider: The plan pays 80% after your $25 copayment; you pay 20%.
- Out-of-network 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. **You must preauthorize.**

17.13

Flu shots

- In-network providers (including BYU Student Health Center): The plan pays 100%; you pay 0%.
- All other providers: The plan pays 50%; you pay 50%.
- One influenza (flu) shot per person is eligible for benefits each academic year.
- For more information about getting your flu shot, call the BYU Student Health Center.

17.14

Gastroenterology services

- In-network provider: The plan pays 80% after your $25 copayment; you pay 20%.
- Out-of-network provider: The plan pays 50% after your $25 copayment; you pay 50%.
- **You must preauthorize.**

17.15

Hearing testing

- In-network provider: The plan pays 80% after your $25 copayment; you pay 20%.
- Out-of-network provider: The plan pays 50% after your $25 copayment; you pay 50%.
- The purchase or fitting of hearing aids isn't eligible for benefits.
- **You must preauthorize.**

17.16

Home healthcare

- In-network provider: The plan pays 80% after your $25 copayment; you pay 20%.
- Out-of-network 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) isn't eligible for benefits.
- **You must preauthorize.**

17.17

Inpatient hospital (including maternity services)

- In-network provider: The plan pays 80%; you pay 20%.
- Out-of-network provider: The plan pays 50%; you pay 50%.
- You pay a $300 copayment per admission ($100 for newborn infants).
- For maternity hospitalization, you must only preauthorize stays of more than two days for vaginal delivery or more than four days for cesarean section delivery. If you don't preauthorize, additional days will be subject to medical review. For preauthorization, contact DMBA before your stay is extended.
- **For other inpatient hospital stays, you must always preauthorize**. For inpatient hospital stays that are the result of an emergency room visit, you have two business days to preauthorize. See *Preauthorization* on page 9 for more information.
- Spouse/dependent(s) are subject to a $3,000 deductible for all maternity services.

17.18

Inpatient physician services

- In-network provider: The plan pays 80%; you pay 20%.
- Out-of-network provider: The plan pays 50%; you pay 50%.
- **You must preauthorize.**

17.19

Laboratory services

- In-network provider: The plan pays 80%; you pay 20%.
- Out-of-network provider: The plan pays 50%; you pay 50%.
- **You must preauthorize services related to genetic testing**. These services will only be preauthorized after consultation with an in-network genetic counselor.

17.20

Mammography

- In-network provider: The plan pays 80%; you pay 20%.
- Benefit available based on medical necessity or the age guidelines established by the U.S. medical profession.

17.21

Maternity—general information

- Covered dependents are subject to a $3,000 deductible per pregnancy for all maternity services in addition to the plan deductible before receiving regular benefits.
- The health centers provide pregnancy tests, but you'll be referred to an in-network provider for other ongoing maternity care.
- Remember, you'll 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 appropriate office within 60 days of the birth (Student Health Plan office at BYU or cashier's office at Ensign College). For more information, see *Changing Enrollment* on page 13. Newborns must be enrolled in coverage for the semester or term they were born.
- Also, you need a referral for any non-maternity GYN care.
- All costs associated with non-licensed birthing centers or planned home delivery for childbirth (including any complications that result from using these services) are excluded by the plan.
- Postpartum pap smears are part of your global maternity care services.

17.22

Maternity—physician/nurse-midwife services

- Covered dependents are subject to a $3,000 deductible per pregnancy for all maternity services in addition to the plan deductible before receiving regular benefits.
- In-network provider: The plan pays 80%; you pay 20%.
- Out-of-network provider: The plan pays 50%; you pay 50%.
- You pay a $25 copayment per visit (maximum total copayment of $250 for routine care).
- **You must receive preauthorization from DMBA.**
- Additional services, such as ultrasounds, are billed separately and normal plan benefits and copayments apply to the additional charges. If other services are recommended by your physician, remember to contact DMBA first for preauthorization. To be eligible for benefits, many of the tests must be provided at the health center.
- Other physicians involved in medical care for you and your baby, such as anesthesiologists or pediatricians, will bill separately. Regular plan benefits and copayments also apply to these charges.

17.23

Medical equipment (durable)

- Durable medical equipment is a device that is durable; primarily serves a medical purpose; generally isn't 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.
- In-network provider: The plan pays 80% after your $25 copayment; you pay 20%.
- Out-of-network 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 more information, please refer to the medical equipment table below. If you don't preauthorize, purchase or rental of 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 costs associated with 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.

This table is not intended to be all-inclusive.

MUST BE PREAUTHORIZED	NO NEED TO BE PREAUTHORIZED	NOT ELIGIBLE FOR BENEFITS

• Airway clearance systems (ThAIRpy vests)
• Bone growth stimulators
• Communication devices
• Continuous glucose monitors
• Enteral infusion pumps/formula
• Eyeglasses/contact lenses (with certain medical diagnoses and/or surgeries)
• Gait trainers
• Helmet therapy
• Hospital beds/mattresses
• Hospital-grade breast pumps (for NICU stays only)
• Hoyer lifts
• Insulin pumps
• Intermittent limb compression devices
• Lymph Presses
• Oxygen concentrators/tanks
• Respirators/ventilators
• Scooters
• Standers
• TENS units/EMS units
• Wheelchairs
	• Apnea monitors (newborns only)
	• Bilirubin lights
	• Blood pressure kits
	• Canes
	• Commodes
	• CPM machines
	• Crutches
	• Glucometers
	• Nebulizers/Pulmo-Aides
	• Orthopedic braces
	• Orthotics
	• Overhead trapeze
	• Oxygen, stationary*
	• Pacemakers
	• Reflux boards
	• Transfer boards
	• Walkers
		• Air filtration systems
		• Exercise equipment
		• Hearing devices
		• Humidifiers/dehumidifiers
		• Interferential stimulators
		• Knee braces used solely for sports
		• Learning devices
		• Lift chairs
		• Modifications associated with:
		  ○ Activities of daily living
		  ○ Homes/structures
		  ○ Vehicles
		• Spa memberships
		• Thermal therapy devices (cold/hot)
		• Whirlpools

* Preauthorization is required after 30 days.

17.24

Medical supplies

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

17.25

Mental health therapy

- In-network provider: The plan pays 80% after your $25 copayment; you pay 20%.
- Out-of-network provider: The plan pays 50% after your $25 copayment; you pay 50%.
- Benefits are limited to 30 outpatient visits.
- The plan covers mental and behavioral health counseling visits performed via telehealth.
- Residential treatment isn't covered.
- To be eligible for benefits, services must be provided by a physician, psychologist, clinical social worker, or advanced practice registered nurse.
- Transcranial magnetic stimulation (TMS) does not count toward the 30 outpatient visit limit. TMS must be preauthorized.
- Office visits and counseling for mental health therapy generally do not require preauthorization. Additional therapeutic interventions such as TMS may require preauthorization.
- Psychological testing, administration, and scoring services are only eligible when received at the health centers.
- You must preauthorize neuropsychological testing, administration, and scoring services.

17.26

Office visits

- In-network provider: The plan pays 80% after your $25 copayment; you pay 20%.
- Out-of-network provider: The plan pays 50% after your $25 copayment; you pay 50%.
- The plan covers medical office visits performed via telehealth (CPT codes 99201-99215).
- Telehealth services performed via "convenient care" or other typically app-based platforms are excluded from coverage.
- Generally, you do not need to preauthorize.

17.27

Pain management

- In-network provider: The plan pays 80% after your $25 copayment; you pay 20%.
- Out-of-network provider: The plan pays 50% after your $25 copayment; you pay 50%.
- The benefit is for either inpatient or outpatient care.
- **You must preauthorize**.

17.28

Physical and occupational therapy—outpatient

- In-network provider: The plan pays 80% after your $25 copayment; you pay 20%.
- Out-of-network 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 don't count toward your annual outpatient visit limit.
- **You must preauthorize**.

17.29

Prescription drugs

From the BYU Student Health Center pharmacy:

- Covered brand-name and generic drugs: The plan pays 80%; you pay 20%.
- Non-covered brand-name and generic drugs: You pay 100% (not covered).
- Benefits are limited to a 30-day supply.
- High-cost and specialty drugs are exclusions of the plan.

From an in-network retail pharmacy:

- Covered brand-name and generic drugs: The plan pays 60%; you pay 40%.
- Non-covered brand-name and generic drugs: You pay 100% (not covered).
- Benefits are limited to a 30-day supply.
- High-cost and specialty drugs are exclusions of the plan.

From an out-of-network retail pharmacy:

- No coverage.

Documented university-sponsored international travel 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 Navitus at 833-354-2226.

Prescription drugs are not included in Large Claims Coverage. If you qualify for Large Claims Coverage, standard prescription benefits will remain in effect. For more information about covered drugs and retail pharmacy locations, call DMBA at 800-777-3622 or call Navitus at 833-354-2226.

17.30

Prosthetics

- This benefit includes prosthetics such as artificial arms or legs.
- In-network provider: The plan pays 80% after your $25 copayment; you pay 20%.
- Out-of-network 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**.

17.31

Radiation therapy

- In-network provider: The plan pays 80%; you pay 20%.
- Out-of-network provider: The plan pays 50%; you pay 50%.
- **You must preauthorize**.

17.32

Radiology services (X-rays, CT scans, MRIs, ultrasounds, etc.)

- The plan pays 80% after your $25 copayment; you pay 20%.
- **You must preauthorize certain services**. For more information, contact DMBA.

17.33

Skilled nursing

- In-network provider: The plan pays 80% after your $25 copayment; you pay 20%.
- Out-of-network 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.

17.34

Substance abuse

- In-network provider: Plan pays 80% after $25 copayment (for outpatient services); you pay 20%.
- Out-of-network provider: The plan pays 50% after your $25 copayment; you pay 50%.
- Benefits are limited to 30 inpatient days and 30 outpatient visits.
- Residential treatment isn't covered.
- **You must preauthorize**. All preauthorizations are confidential.

17.35

Surgery—outpatient hospital services

- In-network provider: The plan pays 80% after your $25 copayment; you pay 20%.
- Out-of-network provider: The plan pays 50% after your $25 copayment; you pay 50%.
- **You must preauthorize**.

17.36

Surgery—physician services

- In-network provider: The plan pays 80% after your $25 copayment; you pay 20%.
- Out-of-network provider: The plan pays 50% after your $25 copayment; you pay 50%.
- **You must preauthorize**.

17.37

Urgent care facility (walk-in clinic)

- The plan pays 80% after your $25 copayment; you pay 20%.
- The facility must bill the visit as urgent care.
- You don't need to authorize the initial visit but **must preauthorize any follow-up care with DMBA**.
- For more information about what to do in an emergency, see *Emergencies* on page 30.
- Excludes retail convenient care clinics.

17.38

Well-child/baby care and immunizations

- In-network provider: The plan pays 80% after your $25 copayment; you pay 20%.
- Out-of-network provider: The plan pays 50% after your $25 copayment; you pay 50%.
- **You must preauthorize**.
- The plan pays for well-child immunizations for children younger than 18 only.

18

DMBA's Preferred Provider Network

If you're away from the area while you're enrolled in the Student Health Plan, you may receive services from any qualified, appropriately licensed provider. However, it is to your advantage to make sure the physicians and hospitals providing your medical care are part of DMBA's preferred provider network. Your benefits will be higher and providers won't bill you for amounts that exceed DMBA's allowable limit.

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 call the appropriate telephone number. Be sure to identify yourself as a participant in a DMBA plan.

Remember, eligible expenses for services from in-network providers are covered at 80% while eligible expenses from out-of-network providers are covered at 50%.

18.1

Find an In-network Provider

Utah and Southeast Idaho: DMBA's Preferred Provider Network
800-777-3622 or www.dmba.com (click on *Find a Provider*)

All other states: UnitedHealthcare Options PPO
866-633-2446 or www.myuhc.com

Hawaii: MDX Providers
808-466-4077

19

Emergencies

19.1

Life-threatening Emergencies

If you're faced with a life-threatening emergency, you should seek immediate medical treatment from a qualified, accessible provider. See *Emergency Room* on page 22.

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.

19.2

Other Medical Emergencies

Other medical emergencies are those that aren't 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 isn't life-threatening, contact a health center immediately. You'll be instructed to go either to the health center or to another emergency-care provider for treatment. If the health center is closed, contact an after-hours facility or go directly to an urgent care facility or emergency room in the community. (Urgent care facilities are available in many areas. If your situation isn't life-threatening but needs immediate attention, an urgent care facility can often provide a less expensive alternative to a hospital emergency room.)

If you receive services in an emergency room and you're subsequently admitted to the hospital, you must call DMBA to preauthorize the admission within two business days. If you receive emergency care in a physician's office after business hours. To ask about services that may require preauthorization, call DMBA at 800-777-3622.

19.3

Follow-up to Emergency Care

For all emergencies, contact DMBA at 800-777-3622 before you receive any follow-up care. Most follow-up care can be provided at the health centers. If you need to receive follow-up care outside of the health centers, your provider may need to preauthorize services before you receive the care.

20

Submitting Claims for Payment

To receive plan benefits for services provided outside of the health centers, submit an itemized bill to DMBA, P.O. Box 45530, Salt Lake City, UT 84145.

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

21

Large Claims Coverage

The plan provides Large Claims Coverage for all 3/4-time continuing students and their eligible dependents. All enrollees of the Student Health Plan are eligible for the Large Claims Coverage Plan, regardless of enrollment hours. This plan is separate from the Student Health Plan, and you don't need to be enrolled in the Student Health Plan to be covered by the Large Claims Coverage Plan.

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

To be eligible for Large Claims Coverage, individuals (students and/or eligible dependents) must document $5,000 worth of plan benefit responsibility (the amount you pay after plan benefits apply, or coinsurance if on a plan not offered by DMBA) per academic year. The following expenses do not apply towards eligibility:

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

After eligibility requirements are met, all eligible expenses that aren't covered by a group plan or other primary insurance will be covered at 100% to a maximum of $380,000 per person per academic year.

Prescription drugs are not included in Large Claims Coverage. If you are enrolled in the Student Health Plan, standard prescription benefits will remain in effect.

If the accident or medical condition causes you to drop out of school, your Large Claims Coverage will be extended for six months beyond the last semester or term you were enrolled. Contact DMBA if you need assistance from the Large Claims Coverage Plan or for more information about the plan's coverage and limitations.

22

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 isn't a citizen of the country), the plan will pay expenses for returning the body to the country of citizenship up to a maximum benefit of $7,500. To be eligible for coverage, expenses must be approved in advance. Please call DMBA at 800-777-3622 for more information.

23

Exclusions

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

23.1

Alternative care

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

23.2

Congenital anomalies

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

23.3

Convenience/cosmetic services

3.1 Care, treatment, supplies, or other services primarily for convenience, contentment, non-therapeutic purposes, or aren't 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.
3.3 Care, treatment, diagnostic procedures, or other expenses for an abdominoplasty, breast reduction, lipectomy, panniculectomy, skin furrow removal, or diastasis rectus repair.

23.4

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.

23.5

Dental care

5.1 Dental treatment, except when made necessary by accidental injury to sound, natural teeth, as provided by the plan.

23.6

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 DMBA 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 DMBA 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 of the clinical trial or research setting.
- The available research about the technology must be substantial. For plan purposes, substantial means sufficient to allow DMBA to conclude the technology is:
  - Both medically necessary and appropriate for the covered person's treatment
  - Safe and efficacious
  - More likely than not will be beneficial to the covered person's health
  - Must be generally recognized as appropriate by the regional medical community as a whole

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're specifically included in the medical benefit by DMBA.

23.7

Educational programs

7.1 Educational programs (except diabetes education) provided outside of the health centers (PMS clinics, etc.).

23.8

Fertility/family planning/home delivery

8.1 Reproductive organ prostheses.

8.2 Care, treatment, or operations received outside of the health centers in connection with sexual dysfunction.

8.3 Care, treatment, or operations received outside of the health centers in connection with infertility (except for intrauterine insemination that satisfies the criteria in DMBA's current medical policy).

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

8.5 Abortions, except in cases of rape or incest or when the life of the mother would be seriously endangered if the fetus were carried to term.

8.6 Sterilization procedures.

8.7 Planned home delivery for childbirth and all associated costs.

8.8 Services related to the evaluation and treatment of the cause(s) of multiple miscarriages.

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.

8.10 Genetic testing is not covered if it is related to fertility.

23.9

Government/war

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

9.2 Services covered or that could have been covered by any governmental plan had the participant complied with the requirements of the plan, including but not limited to Medicare and Medicaid.

9.3 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.

23.10

Hearing

10.1 The purchase or fitting of hearing devices.

23.11

Immunizations

11.1 Preventive medicine or vaccines for individuals aged 18 or older, including immunizations, unless otherwise provided for by the terms of the plan.

23.12

Legal exclusions

12.1 Services provided before coverage begins, including hospital stays in progress on the effective date of coverage.
12.2 Accidents sustained as a result of play, practice, or participation in intercollegiate sports (NCAA-sanctioned), the ROTC program, professional contests, or vehicular contests.
12.3 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.
12.4 Services the individual isn't, in the absence of this coverage, legally obligated to pay.
12.5 Conditions resulting from catastrophic events defined as an earthquake, fire, terrorist attack, any other accidental occurrence or series of one event, or a group of related events within seven days or less resulting in the death or serious injury of 20 or more covered students.
12.6 Complications resulting from excluded services.
12.7 Services not specified as covered.
12.8 Care, treatment, or operations incurred after coverage ends.

23.13

Medical equipment

13.1 Multipurpose equipment or facilities, such as those listed in the *Medical Equipment* table on page 25.

23.14

Medical necessity

14.1 Treatment or removal of warts, toenails, corns, or calluses received outside of the health centers.
14.2 Care, treatment, or operations for bunions received outside of the health centers.
14.3 Cardiopulmonary fitness training or conditioning (meaning reimbursement for gym, health, or fitness club memberships or fees), either as a preventive or therapeutic measure.
14.4 Care or treatment of acne received outside of the health centers.

23.15

Mental health/counseling/substance abuse

15.1 Marriage/family counseling received outside of health centers, recreational therapy, or therapy over the phone.
15.2 Inpatient care or treatment received in connection with anorexia, bulimia, or other eating disorders.

15.3 Care or treatment for anorexia, bulimia, other eating disorders, mental health, counseling, or substance abuse rendered in a residential treatment center or partial hospitalization setting.
15.4 Evaluation and/or treatment outside of the health centers for learning disabilities and/or physical or mental developmental delay, including pervasive developmental disorders, autism, and/or cognitive dysfunctions.
15.5 Mental or emotional conditions without manifest psychiatric disorder as described in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM), or with non-specific symptoms.

23.16

Miscellaneous

16.1 Physical exams for the purpose of obtaining insurance, employment, or government licensing.
16.2 Care, treatment, diagnostic procedures, equipment, or any other services for sleep disorders, chronic fatigue, or fibromyalgia (except for obstructive sleep apnea treatment that satisfies the criteria in DMBA's current medical policy).
16.3 DMBA excludes sex change operations and all associated procedures and services (medical, psychological, pharmaceutical, surgical, etc.) from benefits in all medical plans.
16.4 Care, treatment, diagnostic procedures, or other expenses when it has been determined by DMBA that brain death has occurred (see exclusion 2.1 for exceptions).
16.5 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.
16.6 Treatment received outside of the health centers in connection with aviation-related accidents (including but not limited to parachuting, hang gliding, or ballooning events), other than for passengers on scheduled commercial airlines.

23.17

Obesity

17.1 Care, treatment, or operations received outside of the health centers in connection with obesity or weight loss (including gastric bypass surgery).

23.18

Other insurance/workers' compensation

18.1 Services covered or that could have been covered by applicable workers' compensation statutes.
18.2 Services or materials covered or that could have been covered by insurance required or provided by any statute had the participant complied with the statutory requirements, including but not limited to no-fault insurance, except as provided at the health centers.
18.3 Services received outside of the health centers for which a third party, the liability insurance of a third party, or the uninsured motorist insurance pays or is obligated to pay.

23.19

Pain control

19.1 Services received outside of the health centers for spinal cord stimulators.

23.20

Prescription drugs, specialty pharmacy medications, formulas, supplements

20.1 Dietary products, nutritional or food supplements, and special diets except to the extent specifically provided in the plan (including any requirements regarding preauthorization).

20.2 Prescription drugs, high-cost injections, or specialty pharmacy medications for conditions including but not limited to hemophilia (i.e., Factor Products, BeneFix); multiple sclerosis (Avonex or Copaxone); HIV/AIDS; hepatitis C (Peg-Intron); oral or self-administered chemotherapy agents (Gleevec, Procrit, or Epogen); infertility injections; Crohn's disease (Remicade); rheumatoid arthritis (Raptiva or Enbrel); growth hormone deficiencies (Humatrope or Nutropin); asthma (Xolair); diabetes (Byetta); or hypercoagulability (Lovenox).

20.3 Excluded medications such as 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.

23.21

Routine services

21.1 Annual routine physical exams **outside of the health centers**.

21.2 Services received outside of the health centers for routine pap smears (other than prenatal), premarital services, X-ray exams, psychological testing, and screening exams except for mammograms and colonoscopies (45 and older) that satisfy the criteria in DMBA's current medical policy.

23.22

Speech therapy

22.1 Speech therapy and evaluation.

23.23

TMJ

23.1 Services, materials, or operations in connection with disturbances of the temporomandibular joint (TMJ).

23.24

Testing

24.1 Diagnostic services that are received outside of the health centers and aren't related to an injury or illness, unless otherwise provided for by the plan.

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

24.3 Genetic testing is only covered when it will directly impact the health of the person requesting it and when it's recommended by a genetic counselor.

23.25

Transplants

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

23.26

Vision

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

24

Claims Review Procedures

If you have questions, concerns, or complaints, please bring them to our attention. This includes complaints about the health centers, in-network and out-of-network physicians and facilities, administrative procedures, claims payments, or preauthorization procedures.

If you have concerns about the BYU Student Health Center, its staff, or services you receive there, please call DMBA's Student Health Plan representative at 800-777-3622, extension 8837.

If you have concerns about services you received outside of the health centers, please contact the Student Health Plan team at DMBA at 800-777-3622, extension 8837.

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

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

The committee meets on a monthly basis and includes representatives of the student body, physicians, legal counsel, and consulting professional personnel from the health centers and DMBA.

All appeals must be received within 12 months of the original date of benefit determination. Please refer to the table below that shows when you must submit appeal requests, as well as when you can expect written responses to those requests.

	URGENT CARE CLAIMS	PRE-SERVICE CLAIMS	POST-SERVICE CLAIMS
DMBA must provide notice of the initial claim denial by . . .	72 hours after receiving the claim if it was properly completed. 48 hours: (1) after receiving completed claim or (2) after the 48-hour claimant deadline, whichever is earlier.	15 days after receiving the initial claim. 30 days after receiving the claim if we need more information and we provide an extension notice during the initial 15-day period.	30 days after receiving the initial claim. 45 days after receiving the claim if we need more information and we provide an extension notice during the initial 30-day period.
DMBA must provide an incomplete claim notice and request additional information by . . .	24 hours after receiving claim	5 days after receiving claim	30 days after receiving claim, extended 15 days from the date we receive the required information
Claimant must complete claim by . . .	Not applicable	45 days after receiving notice to provide information	45 days after receiving notice to provide information
Claimant must appeal decision by . . .	12 months after receiving the claim denial	12 months after receiving the claim denial	12 months after receiving the claim denial
DMBA must provide a notice of decision of appeal by . . .	72 hours after request for review (either verbal or written)	30 days. Two levels of review are available: CMRC will respond within 15 days of written request. CRC will respond within 15 days of request (either verbal or written)	60 days. Two levels of review are available: CMRC will respond within 30 days of written request. CRC will respond within 30 days of request (either verbal or written)

25

Subrogation

If you have an injury that is the liability of another party and you have the right to recover damages, DMBA has the right of subrogation and will require reimbursement for any amount it has paid when damages are recovered from the third party. DMBA 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 DMBA benefits for the injury constitutes subrogation. You must provide any information DMBA requests for subrogation purposes. If you fail to do so, you'll be responsible for reimbursing all the costs and expenses paid by DMBA for the injury.

Important Dates

BRIGHAM YOUNG UNIVERSITY		
FALL SEMESTER 2025	Sep. 3	Coverage effective; fall semester premiums due. If you are waiving the Student Health Plan, private health coverage must be effective.
	Sep. 10	Last day for students to submit enrollment or certification of other coverage. If you don't pay premiums for fall semester, holds will be place on your financial account.
	Jan. 6	Fall semester coverage ends; coverage ends for students leaving school.*
WINTER SEMESTER 2026	Jan. 7	Coverage effective; winter semester premiums due. If you are waiving the Student Health Plan, private health coverage must be effective.
	Jan. 14	Last day for students to submit enrollment or certification of other coverage. If you don't pay premiums for winter semester, holds will be place on your financial account.
	Apr. 27	Winter semester coverage ends; coverage ends for students leaving school.*
SPRING TERM 2026	Apr. 28	Coverage effective; spring term premiums due. If you are waiving the Student Health Plan, private health coverage must be effective.
	May 5	Last day for students to submit enrollment or certification of other coverage. If you don't pay premiums for spring term, holds will be place on your financial account.
	Jun. 21	Spring term coverage ends.
SUMMER TERM 2026	Jun. 22	Coverage effective; summer term premiums due. If you are waiving the Student Health Plan, private health coverage must be effective.
	Jun. 29	Last day for students to submit enrollment or certification of other coverage. If you don't pay premiums for spring term, holds will be place on your financial account.
	Sep.1	Summer term coverage ends; 2024-2025 coverage ends for continuing students; coverage ends for students leaving school.*

* Students who graduate or lose their continuing student status.

ENSIGN COLLEGE		
FALL SEMESTER 2025	Sep. 2	Semester and block 1 classes start and coverage begins. Premium due.
	Oct. 17	Block 1 classes end.
	Oct. 26	Block 1 coverage ends.
	Oct. 27	Block 2 classes start and coverage begins. Premium due.
	Dec. 12	Semester and block 2 classes end.
	Jan. 4	Semester and block 2 coverage ends.
WINTER SEMESTER 2026	Jan. 5	Semester and block 1 classes start and coverage begins. Premium due.
	Feb. 20	Block 1 classes end.
	Mar. 1	Block 1 coverage ends.
	Mar. 2	Block 2 classes start and coverage begins. Premium due.
	Apr. 16	Semester and block 2 classes end.
	May 3	Semester and block 2 coverage ends.
SPRING SEMESTER 2026	May 4	Semester and block 1 classes start and coverage begins. Premium due.
	Jun. 18	Block 1 classes end.
	Jun. 28	Block 1 coverage ends.
	Jun. 29	Block 2 classes start and coverage begins. Premium due.
	Aug. 14	Semester and block 2 classes end.
	Aug. 30	Semester and block 2 coverage ends.

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Coordination of Benefits

The Student Health Plan adheres to appropriate coordination of benefits guidelines and regulations.

28

Notification of Benefit Changes

DMBA reserves the right to amend or terminate the plan at any time. If benefits change, we'll 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.

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Notification of Discretionary Authority

DMBA and the BYU Student Health Center have full discretionary authority to interpret the plan and to determine eligibility. DMBA and the BYU Student Health Center have the sole right to construe plan terms. All DMBA and BYU Student Health Center decisions relating to plan terms or eligibility are binding and conclusive.

30

Fraud Policy Statement

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

31

Legal Notice

This handbook provides you with an explanation of your benefits under the Student Health Plan and constitutes a legal contract between you and DMBA.

32

Definitions

32.1

Academic school year

The academic school year for 2025–2026 is September 3, 2025, to September 2, 2026. The academic year is also considered the plan year.

32.2

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 isn't the result of illness.

32.3

Acute

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

32.4

Allowable limit

The maximum dollar amount DMBA will pay for a defined procedure.

32.5

Alternative care

Outpatient treatment for mental illness in lieu of inpatient care if you qualify for inpatient care and can be discharged from an inpatient acute care setting to a less expensive setting, such as day treatment or partial day treatment, without compromising the quality of care.

32.6

Copayment

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

32.7

Custodial care

Maintaining a patient beyond the acute phase of injury or illness. Custodial care includes room, meals, bed, or skilled medical care in a 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.

32.8

Deductible

The amount you pay out of pocket before plan benefits apply.

32.9

Elective surgery

Operations or surgical procedures for a condition that isn't immediately life-threatening, and the timing is subject to the choice or decision of the patient and the physician.

32.10

Eligibility date

The date you become eligible for benefits.

32.11

Eligible charges/expenses

Expenses incurred by you or a dependent for treatment of injury or illness 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 limits defined by DMBA 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.

32.12

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 104º Fahrenheit.

32.13

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.

32.14

Illness

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

32.15

In-network facilities

Hospitals, labs, and healthcare facilities that have contracted with DMBA to provide services to participants.

32.16

In-network providers

Physicians, specialists, and other healthcare providers who have contracted with DMBA to provide services to participants.

32.17

Medical equipment

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

32.18

Medical supply

Medical items that are for immediate use, are disposable, and aren't reusable.

32.19

Medical treatment

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

32.20

Out-of-network facilities

Hospitals, labs, and other healthcare facilities that haven't contracted with DMBA to provide services to participants.

32.21

Out-of-network providers

Physicians, specialists, and other healthcare providers who haven't contracted with DMBA to provide services to participants.

32.22

Participant responsibility

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

32.23

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.

32.24

Preauthorization

A process of advance notification that is required for certain services. When you preauthorize medical care with DMBA, you receive guidelines about which services are eligible for benefits before you commit to the costs.

32.25

Qualifying event

A change in your situation—such as getting married, having a baby, or losing health coverage—that makes you eligible to change your Student Health Plan enrollment.

32.26

Repatriation

The return of someone to his or her own country.

32.27

Residential treatment center

A facility that is licensed by the state to provide residential treatment that has licensed, clinical professionals providing specific treatment for mental illness, substance abuse, eating disorders, etc.

32.28

Surgical center

A 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 doesn’t provide services or other accommodations for patients to stay overnight

Index

BRIGHAM YOUNG UNIVERSITY
FOUNDED
BYU
1875
PROVO, UTAH

ENSIGN
COLLEGE

DMBA

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