TO ALL STUDENTS

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.

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.

Medical Coverage Requirement

If you are a continuing student who is enrolled at least 3/4 time, you must have 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 your first semester or term and annually at the beginning of fall semester. Carefully review any medical plan you're considering to make sure it will provide you with sufficient coverage for your current and future healthcare needs. **Coverage must be effective by the first day of class.** The Student Health Plan office (located at the BYU SHC 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 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 contact the Student Health Plan Office via YMessage or in person to enroll. Graduate students who have a least two credits during fall semester and were enrolled in the Student Health Plan for summer term will be automatically 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.

HOW THE PLAN WORKS

Medical care that is 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 contracted medical providers in the community. 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 medical care.

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 10.)

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 pages 9-11.

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.

Preauthorization

For services received outside of the health center to be eligible for maximum benefits, you must preauthorize them before you receive the medical care. If you don't preauthorize, you may be responsible for an additional $100 copayment for each service. For more information, see page 16.

HOW MEDICAL SERVICES ARE PAID

Overview

In most cases, you pay a copayment to the provider of the care at the time you receive the service. This is a fixed dollar amount (for example, $25 for most services outside of the health centers). After your copayment, the amount covered by the plan (for example, 80%) is your **plan benefit**, and the amount you pay (the remaining 20%) is the **participant responsibility** (see page 8).

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*.**

The enrollment deadlines are specified in the calendars on page 33.

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.

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 Student Health Plan office at BYU, or registration office at Ensign College). You will be charged the appropriate married student premium for the semester/term the marriage occurs.

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 last day to add/drop.

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 13). 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.

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; it isn't done for you automatically when the child is born.)

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 at least 3/4 time, but you don't lose your status as a continuing student, you'll be covered by the Away-from-Campus option of 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 Away- from-Campus option of 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 on page 10. 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 medical care at one of the health centers if you're in the area. Otherwise, you may receive your medical care from any qualified, appropriately licensed medical provider. However, it will be to your advantage to use providers who are part of DMBA's national Preferred Provider Network whenever possible (see page 24). **You must still preauthorize any care you receive outside of the health centers.**

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. (Please see the calendars on page 33 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 25).

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, complete an Extended Coverage enrollment form at 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 your medical care from any qualified, appropriately licensed medical provider. However, it will be to your advantage to use providers

Utah), call DMBA at 800-777-3622. If you are outside of the United States, you must preauthorize services by calling DMBA at 800-777-3622, or by faxing information to 801-578-5916.

If your preauthorized provider recommends care that isn't preauthorized by the health center or DMBA (such as additional office visits, tests at another facility, or consultation with another healthcare provider), you 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.

If you receive medical care outside of the health centers without preauthorization, your copayment will increase to $100 per service. If you don't preauthorize hospital admission, you must pay an additional $100 copayment per admission.

If you receive services in an emergency room and are 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, you must also call DMBA for preauthorization.

Even if you have preauthorization to see an outside provider, the authorization doesn't guarantee payment for the treatment you receive. Plan guidelines, benefits, and exclusions will determine claims payment for all services.

COVERED SERVICES

For information about the benefits payable for services outside of the health centers, see the table on page 8. If you have questions about benefits or preauthorization requirements for any medical service, call the Student Health Plan team at DMBA. The following pages list examples of the services the plan covers outside of the health centers.

ALLERGY SERVICES

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

AMBULANCE (LAND AND AIR)

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

ANESTHESIA

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

CARDIOVASCULAR SERVICES

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

CHEMOTHERAPY

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

DENTAL ACCIDENT BENEFIT

- The plan pays 80% after your $25 copayment; you pay 20%.
- The maximum benefit is $3,000 per plan year.
- Benefits apply only to services made necessary as a direct result of a traumatic accidental injury (such as a car accident or 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.
- **You must preauthorize.**

DIABETES EDUCATION

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

DIABETIC SUPPLIES

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

DIALYSIS

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

EMERGENCY ROOM

- If care at an urgent care facility is appropriate, it is a less expensive alternative (see page 23).
- The plan pays 80% after your $50 copayment; you pay 20%.
- You don't need to authorize the initial visit, but **you must preauthorize any follow-up care with DMBA.**

EYE EXAMS

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

FLU SHOTS

- Contracted providers (including BYU Student Health Center or VRx Pharmacy): 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 or VRx Pharmacy.

GASTROENTEROLOGY SERVICES

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

HEARING TESTING

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

HOME HEALTHCARE

- Contracted provider: The plan pays 80% after your $25 copayment; you pay 20%.
- Non-contracted provider: The plan pays 50% after your $25 copayment; you pay 50%.
- To be eligible for benefits, services must be performed by a licensed registered nurse or a licensed practical nurse.
- Custodial care (such as maintaining someone beyond the acute phase of injury or illness including room, meals, bathing, dressing, and home health aides) isn't eligible for benefits.
- **You must preauthorize.**

INPATIENT HOSPITAL (INCLUDING MATERNITY SERVICES)

- Contracted provider: The plan pays 80%; you pay 20%.
- Non-contracted provider: The plan pays 50%; you pay 50%.
- You pay a $300 copayment per admission ($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 and an additional $100 copayment. For preauthorization, contact DMBA before your stay is extended.
- **For other inpatient hospital stays, you must always preauthorize.** If you don't preauthorize your hospital stay, you'll be charged an additional $100 copayment. For inpatient hospital stays that are the result of an emergency room visit, you have two business days to preauthorize. See page 16 for more information.
- Non-student dependents are subject to a $3,000 deductible for all maternity services.

INPATIENT PHYSICIAN SERVICES

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

LABORATORY SERVICES

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

MAMMOGRAPHY

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

MATERNITY–GENERAL INFORMATION

- Non-student dependents are subject to a $3,000 deductible per pregnancy for all maternity services before receiving regular benefits.
- The health centers provide pregnancy tests, but you'll be referred to a contracted 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 page 10. 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 birthing centers or planned home delivery for childbirth (including any complications that result from using these services) are excluded by the plan.

MATERNITY–PHYSICIAN/NURSE-MIDWIFE SERVICES

- Non-student dependents are subject to a $3,000 deductible per pregnancy for all maternity services before receiving regular benefits.
- Contracted provider: The plan pays 80%; you pay 20%.
- Non-contracted provider: The plan pays 50%; you pay 50%.
- You pay a $25 copayment per visit (maximum total copayment of $250 for routine care).
- **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 the medical care for you and your baby, such as anesthesiologists or pediatricians, will bill you separately. Regular plan benefits and copayments will also apply to these charges.

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.
- Contracted provider: The plan pays 80% after your $25 copayment; you pay 20%.
- Non-contracted provider: The plan pays 50% after your $25 copayment; you pay 50%.
- To be eligible for benefits, you must have a prescription from your physician.
- **You must preauthorize certain medical equipment.** For information about equipment requiring preauthorization, please refer to the table on page 21. If you don't, the purchase or rental of the equipment will be reviewed retrospectively (after the fact) to determine if it is eligible for coverage.
- Time limitations apply to replacing some equipment.

OFFICE VISITS

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

PAIN CLINICS

- Contracted provider: The plan pays 80% after your $25 copayment; you pay 20%.
- Non-contracted provider: The plan pays 50% after your $25 copayment; you pay 50%.
- The benefit is for either inpatient or outpatient care.
- Outpatient services have a five-visit or $1,500 benefit limit. Each visit is subject to the contracted and non-contracted rates after your $25 copayment.
- **You must preauthorize.**

PHYSICAL AND OCCUPATIONAL THERAPY–OUTPATIENT

- Contracted provider: The plan pays 80% after your $25 copayment; you pay 20%.
- Non-contracted provider: The plan pays 50% after your $25 copayment; you pay 50%.
- The plan covers up to 20 visits per person per academic year.
- Inpatient visits don't count toward your annual outpatient visit limit.
- **You must preauthorize.**
- **In Utah County, you must receive care at the BYU Student Health Center.**

PRESCRIPTION DRUGS

From the SHC pharmacy:

- Covered brand-name and generic drugs: The plan pays 80%; you pay 20%.
- Non-covered brand-name and generic drugs: You pay 100%.
- Benefits are limited to a 30-day supply.
- High-cost and specialty drugs are exclusions of the plan.

From a 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%.
- Benefits are limited to a 30-day supply.
- High-cost and specialty drugs are exclusions of the plan.

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 VRx at 801-417-9722 or 877-879-9722.

Prescription drugs are not included in Large Claims Coverage (see page 25). 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 801-578-5600 in the Salt Lake City area or toll free at 800-777-3622. Or call VRx at 801-417-9722 or 877-879-9722.

PROSTHETICS

- This benefit includes prosthetics such as artificial arms or legs.
- Contracted provider: The plan pays 80% after your $25 copayment; you pay 20%.
- Non-contracted provider: The plan pays 50% after your $25 copayment; you pay 50%.

- To be eligible for benefits, you must have a prescription from your physician.
- **You must preauthorize.**

RADIATION THERAPY

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

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

- The plan pays 80% after your $25 copayment; you pay 20%.
- **You must preauthorize.**

SKILLED NURSING

- Contracted provider: The plan pays 80% after your $25 copayment; you pay 20%.
- Non-contracted provider: The plan pays 50% after your $25 copayment; you pay 50%.
- **You must preauthorize.**
- Time in an extended care facility must occur after an inpatient hospitalization.
- If the care is for recuperating or convalescing from an acute injury or illness, the maximum benefit is 50 days per academic year.
- Custodial care (such as maintaining someone beyond the acute phase of injury or illness, including room, meals, bathing, and dressing) is not covered.

SUBSTANCE ABUSE

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

SURGERY–OUTPATIENT HOSPITAL SERVICES

- Contracted provider: The plan pays 80% after your $25 copayment; you pay 20%.
- Non-contracted provider: The plan pays 50% after your $25 copayment; you pay 50%.
- **You must preauthorize.** If you don't preauthorize, you'll be charged an additional $100 copayment.

SURGERY–PHYSICIAN SERVICES

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

URGENT CARE FACILITY (WALK-IN CLINIC)

- The plan pays 80% after your $25 copayment; you pay 20%.
- You don't need to authorize the initial visit, but **you must preauthorize any follow-up care with DMBA.**
- For more information about what to do in an emergency, see page 24.

WELL-CHILD CARE AND IMMUNIZATIONS

- Contracted provider: The plan pays 80% after your $25 copayment; you pay 20%.
- Non-contracted provider: The plan pays 50% after your $25 copayment; you pay 50%.
- **You must preauthorize.**
- The plan pays for well-child immunizations for children younger than 18.

DMBA'S PREFERRED PROVIDER NETWORK

If you're away from the area while you're enrolled in the Student Health Plan, you may obtain care from any qualified, appropriately licensed medical provider. However, it is to your advantage to make sure the physicians and hospitals providing your care are contracted as part of DMBA's Preferred Provider Network. Your benefits will be higher and the providers won't bill you for fees that exceed DMBA's allowable charges (see page 34).

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 contracted providers are covered at 80% while eligible expenses from non-contracted providers are covered at 50%.

Find a Contracted Medical Provider

Utah and Southeast Idaho: DMBA Contracted Providers
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 Contracted Providers
808-675-4873

EMERGENCIES

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 18.

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

Other Medical Emergencies

Other medical emergencies are those that 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, you must also call DMBA for preauthorization.

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, you must preauthorize with a health center before you receive the care.

Remember, if you receive follow-up care outside of the health centers without preauthorization, you must pay a $100 copayment per service.

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.

LARGE CLAIMS COVERAGE

The plan provides Large Claims Coverage for all 3/4-time continuing students and their eligible dependents. 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.

Before you can be eligible for benefits, you must document annual charges of $25,000. All eligible expenses that exceed $25,000 and 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.

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.

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:

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.

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.

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.

4. Custodial care

4.1 Custodial care, education, training, or rest cures.

4.2 Inpatient hospitalization or residential treatment for the primary purpose of providing shelter and/or safe residence.

5. Dental care

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

EXCLUSIONS (CONTINUED)

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

8.7 Planned home delivery for childbirth and all associated costs.

8.8 Services related to 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

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.

10. Hearing

10.1 The purchase or fitting of hearing devices.

11. Immunizations

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

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.

EXCLUSIONS (CONTINUED)

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.

13. Medical equipment

13.1 Multipurpose equipment or facilities, such as those listed in the Medical Equipment chart on page 21.

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.

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 for learning disabilities and/or physical or mental developmental delay, including pervasive developmental disorders, autism, and/or cognitive dysfunctions.

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.

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 on page 26 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.

EXCLUSIONS (CONTINUED)

23. TMJ

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

23.2 Jaw surgery (osteotomy).

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.

25. Transplants

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

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.

CLAIMS REVIEW PROCEDURES

If you have questions, concerns, or complaints, please bring them to our attention. This includes complaints about the health centers, contracted and non-contracted 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 5645.

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.

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.

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.

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.

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.

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.

DEFINITIONS

Academic School Year: The academic school year for 2020-2021 is August 31, 2020 to August 29, 2021.

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.

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

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

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.

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

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

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

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

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.

Eligibility Date: The date you become eligible for benefits.

Eligible Charges/Expenses: Expenses incurred by you or a dependent for treatment of injury or illness that are:

- Medically necessary for the care and treatment of the injury or illness and are incurred on the recommendation and while under the continuous care of a physician
- Not in excess of the allowable charges defined by 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.

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.

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

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

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.

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

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

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

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

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.

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

Preauthorization: A process of advance notification that is required for a number of benefits. When you preauthorize services with the health centers or DMBA, you receive guidelines about what services are eligible for benefits before you commit to the costs.

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.

Repatriation: The return of someone to their own country.

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.

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

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