When you’re an SEBT member, you get tools and resources to help you manage your health and your benefits. Plan information and cost-savings tools are in one place — your member website. Sign up at www.mycampusfirst.com and click on your University link. Then go to the VIEW ENROLLMENT button to register!

For details like copays, what’s covered, general benefits and exclusions, check your Summary of Benefits document online at www.mycampusfirst.com (scroll down to find your school). You can also see the Master Policy for a complete description of the benefits and full terms and conditions. If there’s any discrepancy between this Plan Guide, the Summary of Benefits document and the Master Policy, the Master Policy will govern and control the payment of benefits.
Eligibility

**CAMPUSFIRST™ - BRONZE, SILVER, & GOLD PLANS** are comprehensive plans for matriculated Domestic and International Students. It is the intent of these plans to offer coverage that meets or exceeds the Minimum Essential Coverage requirements currently set forth by the Federal Department of Health and Human Services.

Programs that require students to have coverage for the 2017-2018 school year include the MD program, programs in the Colleges of Nursing, Pharmacy & Pharmaceutical Sciences and Health Sciences, as well as student-athletes and students with J-1 visas. The Bronze level plan offers coverage that meets or exceeds the J-1 visa requirements, as set forth by the U.S. Department of State. These students may opt out of the Bronze level plan and choose either the Silver or Gold level plan or may waive out of coverage with proof of comparable other health insurance coverage.

Also eligible are Dependents and spouses of Covered Students of the University (the spouse, domestic partner or unmarried children of the student).

**CAMPUSFIRST™ - SUPPLEMENTAL PLAN** - is intended for those students that have other primary coverage. Services rendered at your Student Health Center will be covered under this plan. It also includes a modest outpatient medical and pharmacy benefit for those students on high deductible health plans, out of state, HMO or other plans with an insufficient local area physician and/or hospital network.

Dependent Coverage

Eligible students who enroll may also insure their eligible dependents. Eligible dependents are the spouse, including domestic partners, and children to the age of 26. Dependent eligibility expires concurrently with that of the insured student. Newborn Infant Coverage and Adopted Child Coverage.

The insured person must (1) enroll the child within 31 days of birth and (2) pay the appropriate premium.

Enroll at MyCampusFirst.com
Providers

Your Student Health Plan allows you to choose whether to receive care from a Network provider, or a provider outside the Network. Using a network provider saves you money and provides better coordinated care.

The Student Health Center (SHC) serves as your Primary Care Provider (PCP), and referrals to other providers may be needed in order to receive payment for coverage.

FINDING A PROVIDER

Our online directory is an easy-to-use search tool that lets you find the right provider in a snap. Just enter a name, ZIP code, condition, procedure or specialty in the search box. You’ll also find maps, directions and more. www.mycampusfirst.com and click on the University link and click FIND A NETWORK PROVIDER or call 877-233-5159 Press 1, choose your school and Press 1 again.

KINDS OF PROVIDERS

**Tier One Providers**

To ensure you receive the highest level of benefits, access Tier 1 providers – Your Student Health Center and Group Specific Network set up by your University. (See your liaison for the list.)

**Tier Two Providers (IN NETWORK)**

Medical Mutual of Ohio maintains the Tier 2 provider network.

**Tier Three Providers (NON-NETWORK)**

You may also access Non-Network Tier 3 providers for medically necessary covered services. You’ll receive the lowest level of benefits and your out-of-pocket costs will be higher than if you accessed care through Tier 1 or Tier 2 In-Network providers.

Important provisions of the student health plan

The Plan will always pay benefits in accordance with any applicable Insurance Law(s).

Before paying or providing benefits under this Plan, SEBT will review the claims to see if any other party might be potentially responsible for making any payment.

If an insured person receives any payment from any other party, SEBT has the right to be reimbursed for all amounts they have paid up to, and including, the full amount the insured person receives.

Others that may be responsible may include but not limited to:

- Primary Coverage through yourself or a parent;
- Automobile Insurance;
- General Liability Insurance;
- Personal umbrella coverage:
- Med-pay coverage;
- Workers compensation coverage.
Your University sponsored Student Health Benefit Plan offers a quick, integrated, inexpensive, round-the-clock solution to provide access to a primary physician care when your Student Health Center is not available to you or your dependents due to limited hours of operation, time of day, or the nature of your medical necessity. Access to this cross coverage service is available in all fifty states and is accessible when your Student Health Center is closed, on vacation or when you are traveling beyond 50 miles from campus.

Please note this service is available at no additional cost to you or your dependents for the actual consultation. The intent of this service is to provide an integrated cross coverage capability and is not intended to replace an urgent care or emergency room. When medically appropriate, this service is able to provide treatments for common illness such as colds, flu, upper respiratory and sinus infections, allergies, bronchitis, and urinary tract infections. If appropriate, the board certified physician may phone a prescription of a non-DEA controlled or lifestyle modification substance into a local pharmacy. As this service is integrated into your Student Health Center, the on-campus medical professional will receive a copy of all consultations performed during the consultation. You may be contacted by the same on-campus medical professional to follow up with the appropriate course of treatment. The 24/7 Physician Service is available toll-free at 877.233.5159 press 5.

Precertification Requirements

This program is designed to help you receive quality, cost-effective medical care. If you do not secure a Pre-Certification for necessary services, your covered medical expenses will be subject to a penalty or not covered. Pre-certification is designed to help you receive quality, cost-effective medical care. Services must be certified in advance by contacting the Precertification Hotline at:

877-233-5159 Press 1, choose your school and Press 2.
Termination of Benefits

Benefits are payable under the Plan only for those Covered Medical Expenses incurred while the Plan is in effect as to the insured person. No benefits are payable for expenses incurred after the date the coverage terminates, except as May be provided under the Extension of Benefits provision.

Extension of Benefits

If a covered person is confined to a hospital on the date his or her coverage terminates, expenses incurred after the termination date and during the continuance of that hospital confinement shall be payable in accordance with the Plan, but only while they are incurred during the 90-day period following such Termination of Coverage.

Voluntary Delta Dental

Who is Eligible?
All students who are eligible for the University student health plan are eligible to participate in the Delta Dental Plan. An enrolled student’s spouse, and dependent children to age 26, are also eligible to purchase this plan.

Effective Dates of Coverage
Eligibility ends when the student is no longer enrolled at the University or the student stops paying premium. Your effective date of coverage is the date of enrollment and premium is received by the company.

Maximum Benefit (Per Calendar Year) $750 per person
Deductible (Per Calendar Year) $50 per person
(does not apply to diagnostic and preventative services, periodontal maintenance and brush biopsy)

Voluntary Davis Vision Plan

Who is Davis Vision?
Davis Vision is one of the nation’s leading managed vision and eye care providers. They administer vision care services and products for 55 million people nationwide. Davis Vision offers a full line of vision care services through the Discount Vision Program. This program is based on annual enrollment which includes two routine eye exams covered in full with significant discounts on eyeglasses and contact lenses. (This is purely a discount program. All existing vision benefits associated with your health plan still apply).

How the Plan Works
- Call the network provider of your choice and schedule an appointment.
- Identify yourself as a member of the University Student Program.
- Provide the office with your student identification number.

It’s that easy to receive services. The provider’s office will verify your eligibility for services, and no claim forms or ID cards are required!
Claims Procedures

Customer Service Representatives are available 8:00 a.m. to 6:00 p.m., Monday through Friday (EST) for any questions.

1. Bills must be submitted from the provider of service within 90 days from the date of treatment.
2. Payment for Covered Medical Expenses will be made directly to the hospital or Physician concerned.
3. Any itemized medical bills should include the student ID number, date of service, name of provider, CPT code, diagnosis code, and should be mailed promptly to the below address. In the event of a disagreement over the payment of a claim, a written request to review the claim must be mailed to Student Educational Benefit Trust within 60 days from the date appearing on the Explanation of Benefits.

Claims Appeals Procedures

Benefits are payable under the Plan only for those Covered Medical Expenses incurred while the Plan is in effect for the insured person. No benefits are payable for expenses incurred after the date the coverage terminates, except as may be provided under the Extension of Benefits provision.

If a claim is wholly or partially denied, a written notice will be sent to the Covered Person containing the reason for the denial. The notice will include a description of any additional information which might be necessary for reconsideration of the claim. The notice will also describe the right to appeal. A written appeal along with any additional information or comments may be sent within 6 months after notice of denial. In preparing the appeal, the Covered Person, or his/her representative, may review all documents related to the claim and submit written comments and issues related to the denial.

The appeal must be in writing and include:
1. The claims information in question;
2. The statement of why the claimant feels the denial or reduced payment was not correct;
3. The name of the health care provider or hospital;
4. The date of service;
5. The place of service;
6. The description of the service; and
7. The charge incurred.
The payment of any co-pays, deductibles, the balance above any coinsurance amount, and any medical expenses not covered are the responsibility of the insured person. To maximize your savings and reduce out-of-pocket expenses, choose the Student Health Center (SHC) or Designated In-Network Provider. It is to your advantage to utilize an In-Network provider because significant savings can be achieved from the substantially lower rates these providers have agreed to accept as payment for their services. Out-of-Network care is subject to reasonable charge allowance maximums. Any charges in excess of the reasonable charge allowance are not covered under the Plan.

### Prescription Drugs

**How to Fill Prescription Medications:**

Your University’s on-campus or designated off-campus Pharmacy is the preferred method of filling prescription medications and will be the most cost effective for you and your dependents. Prescriptions filled through these pharmacies are paid under the preferred network with straight copayments and are inclusive of 31 day supplies. Maintenance prescriptions in excess of 31 days are only available for 2.5 x the copays.

<table>
<thead>
<tr>
<th>Features</th>
<th>Bronze</th>
<th>Silver</th>
<th>Gold</th>
<th>Supplemental</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Annual Maximum</strong></td>
<td>Unlimited</td>
<td>Unlimited</td>
<td>Unlimited</td>
<td>$2,500</td>
</tr>
<tr>
<td><strong>Deductible</strong></td>
<td>$0 / $800 / $1,600</td>
<td>$0 / $600 / $1,200</td>
<td>$0 / $400 / $800</td>
<td>$0 / $350 / $600</td>
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<tr>
<td><strong>Coinsurance</strong></td>
<td>70%/60%/50% ($6,250 max)</td>
<td>80%/70%/60% ($5,250 max)</td>
<td>90%/80%/50% ($4,250 max)</td>
<td>90%/80%/60%</td>
</tr>
<tr>
<td><strong>Emergency Room</strong></td>
<td>$350 Copay</td>
<td>$250 Copay</td>
<td>$150 Copay</td>
<td>90%/80%/60%</td>
</tr>
<tr>
<td><strong>Prescription</strong></td>
<td>$5/$15/$30 UTMC Copay + Coinsurance</td>
<td>$5/$15/$30 UTMC Copay + Coinsurance</td>
<td>$5/$15/$30 UTMC Copay + Coinsurance</td>
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