

2016 - 2017

Dartmouth Student Group Health Plan (DSGHP)

Plan Document

Effective Date: September 1, 2016



Photo: Eli Burak '00

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Hanover, NH 03755-1421

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4th Floor

Email:
Dartmouth.Student.Health
.Plan@Dartmouth.edu
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For The Most Current Information Regarding The Plan, Notices & General
Information, Refer To The DSGHP Website
dartgo.org/studentinsurance

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The DSGHP complies fully with Title IX of the Education Amendments of 1972, Section 504 of the Rehabilitation Act of 1973, and the Age Discrimination Act of 1975, as all three laws were amended by the Civil Rights Restoration Act of 1987. Pregnancy benefits are provided on the same basis as any other temporary disability.

INTRODUCTION

Dartmouth College has prepared this document to help you understand your medical and prescription drug benefits as a participant in the Dartmouth Student Group Health Plan (DSGHP). Please read it carefully. The Schedule of Benefits provides an overview of your coverage. Terms printed in italics are defined in the Definitions section at the end of this *Plan Document*. When an italicized term is capitalized, this means the term appears in the Definitions section and is also a major section heading in this *Plan Document* (e.g., *Covered Expenses/Services*).

Your benefits under the DSGHP are affected by certain limitations and conditions designed to encourage you to be a wise consumer of health services and to use only those services you need. Also, benefits are not provided for certain kinds of treatments or services, even if your *health care provider* recommends them.

To obtain the maximum amount of benefits for elective admissions to a *hospital, hospice facility or skilled nursing facility*, and before receiving any *home health care or home hospice services*, you must notify the DSGHP as described under the Health Care Management Program's prior notification of Hospital admission requirement.

For United States citizens and permanent residents, treatment or services rendered outside the United States of America or its territories are covered on the same basis as treatment or services rendered within the United States. For international students and their covered dependents, such DSGHP benefits are only provided to the extent they are not covered by any other insurance plan, insurance program, or system of socialized medicine.

As used in this document, the term *plan year* is the 12-month period beginning September 1 and ending the subsequent August 31. Benefit Maximums and *deductibles* accumulate during the *plan year*. The word *lifetime* as used in this document refers to the period of time you or your eligible dependents participate in the DSGHP.

The benefits described in this document are effective with the *plan year* beginning on September 1, 2016.



**Double Rainbow Over Dartmouth College
Summer 2013
Photo By: Eli Burakian '00**

DSGHP Coverage and the Patient Protection Affordable Care Act (PPACA)

The Affordable Care Act requires most people to have health care coverage that qualifies as “minimum essential coverage.” This plan does provide minimum essential coverage.

**If you have questions about this notice please contact
Dartmouth Student Group Health Plan
7 Rope Ferry Road, HB# 6143
Hanover, NH 03755-1421
Phone: (603) 646-9438
Email*: Dartmouth.Student.Health.Plan@Dartmouth.EDU.**

Be advised that you may be eligible for coverage under a group health plan of a parent's employer or under a parent's individual health insurance policy if you are under the age of 26. Contact the plan administrator of the parent's employer plan or the parent's individual health insurance issuer for more information.

* Confidential information or personal health information (PHI) should not be sent by email.

ELIGIBILITY AND PARTICIPATION

Student Eligibility

You are eligible for coverage only if enrolled in the DSGHP and if you qualify as one of the following:

- A matriculated, active undergraduate student, in satisfactory standing, making satisfactory progress toward a degree under an approved Dartmouth Plan.
- An active student enrolled in a Dartmouth Exchange Program, but only during the terms of Dartmouth enrollment.
- An active, special, non-Dartmouth student, but only during the terms of Dartmouth enrollment.
- An active graduate student in satisfactory standing, making satisfactory progress toward a Dartmouth degree (with the approval of the appropriate Dean).
- A pre-matriculated student whose enrollment in the DSGHP has been confirmed and who incurs an *injury or illness* within three weeks of matriculation which prevents the individual from registering for classes or attending classes as otherwise required for DSGHP eligible persons. Coverage will be limited to a maximum of one *plan year*.
- First year International Students with F/J visa status will have an effective date 30 days prior to their first term at Dartmouth College.
- An active student is a student who is designated as active in the Dartmouth Student Information System with the approval of the appropriate Dean.

Post-Graduation Coverage

Students who have graduated from Dartmouth College and are participants in the DSGHP for the current *plan year* ending on August 31 and are participating in a Dartmouth-sponsored activity post-graduation may be eligible to apply for up to two months (September 1 – October 31) of DSGHP coverage during the next succeeding *plan year* at no cost. This extended coverage provision applies to any student who is remaining at Dartmouth College and participating in a formal Dartmouth program. The request for Post-Graduation Coverage must designate the period of coverage and must be received by the DSGHP no later than August 1. Any DSGHP covered dependents of a student approved for post-graduation coverage may also have extended coverage under the DSGHP on a pro-rated cost basis for the same period.

Ineligible Students

Students who are benefits-eligible employees of Dartmouth College as determined by Dartmouth College Human Resources Office, students enrolled in correspondence study, non-credit courses (except international students), Internet courses or any continuing education courses, and any class of students and their dependents who are not specifically identified as being eligible for the DSGHP in this *Plan Document* do not qualify for DSGHP coverage.

Dependent Eligibility

Your eligible dependents may participate in the DSGHP, provided you are also currently a participant. Eligible dependents include any of the following:

- Your lawful spouse as defined by applicable state law.
- Your *domestic partner*, as defined in the Dartmouth College Health Service Affidavit of Domestic Partnership.
- A child younger than age 26.
- A *physically or mentally disabled* child of any age, provided the disability began before he or she reached age 26 and while covered under the DSGHP. Coverage may continue for as long as the child remains disabled, unmarried, and wholly dependent upon you for financial support (in accordance with the Internal Revenue Service dependent guidelines). The DSGHP may require you at any time to submit a *physician's* statement certifying the child's *physical or mental disability*.

For purposes of the DSGHP, *child* means any of the following relationships to a DSGHP-covered student:

- Your natural child, including any child for whom you are required to provide coverage under a court order.
- A legally adopted child by you and a child for whom you are the proposed adoptive parent and who has been placed in your care and custody during the waiting period before the adoption becomes final.
- A child of your *domestic partner*.
- A stepchild.
- A foster child.

If you and your spouse or *domestic partner* are both students, only one of you may cover a dependent child. In addition you may not participate in the DSGHP as both a student and a dependent at the same time.



SCORE!

**Dartmouth scores at the
Homecoming Game against Yale**

Photo By: Jacob Kupferman '14

ENROLLMENTS

Student Enrollment

You are automatically enrolled in the DSGHP unless you submit an approved waiver within the time period described by Dartmouth College (refer to the web site for the waiver requirements at dartgo.org/studentinsurance). Your coverage will become effective as described in When Coverage Begins.

Dependent Enrollment

To obtain immediate coverage under the DSGHP, you must enroll your eligible dependents in the DSGHP within 31 days of when you enroll at Dartmouth College. If you do not have any eligible dependents at the time of initial enrollment but acquire eligible dependents at a later date, you must enroll your dependents within 31 days of the date you acquire them. You may also enroll your eligible dependents during the annual *open enrollment period* in September of each *plan year*. Coverage will become effective as described in When Coverage Begins.

Your newborn child (born to either a male or female DSGHP-covered parent) is automatically covered at birth for 31 days. For coverage to continue beyond 31 days, you must notify the DSGHP by submitting a Dependent Application of the birth and pay any required prorated premium during the 31-day period following the birth. If you fail to do so, coverage will terminate at the end of the 31 days following your child's birth. Prior notification of hospital admission under the Health Care Management Program, or claims for maternity expenses do not qualify as birth notification to the DSGHP.

Late Enrollment and Mandatory Enrollment of Uninsured

If you waived coverage under the DSGHP for yourself or your dependents because you or they had coverage under an individual or group health plan, and that coverage ends for any reason other than non-payment of premium, or separation, resignation or withdrawal from Dartmouth, you may enroll yourself and/or your dependents in the DSGHP at any time, provided you do so within 31 days of the date coverage under the other plan ends. Documentation of the involuntary loss of coverage must be provided to the DSGHP before such enrollment will be accepted.

If you do not enroll within such 31-day period, you will not be allowed to enroll in the DSGHP until the next *open enrollment period* for the next *plan year*.

Late enrollments are subject to all limitations, provisions, and requirements of the DSGHP. Late enrollees pay a prorated premium.

Students who are subject to the Dartmouth College insurance requirement and are discovered to be uninsured during the course of the plan year, and who are otherwise uninsured, will be enrolled in the DSGHP from the date they are determined by Dartmouth College to be without health insurance coverage. The student will be required to pay for the full annual premium for the DSGHP, and not a prorated premium.

EFFECTIVE DATES

~When Coverage Begins

Your coverage begins on the earlier of September 1 or the date you are required to be at Dartmouth College (including periods other than the beginning of the fall semester) for a Dartmouth-sponsored activity. In no event, however, will your coverage begin prior to August 1. If your coverage begins prior to September 1, benefits will be determined based on the schedule of coverage for the DSGHP for the preceding plan year for any medical expenses incurred prior to September 1. There is no additional charge for this early period of coverage.

Coverage for your dependents begins (upon enrollment in the DSGHP) either the date your coverage begins or the first day a dependent is legally acquired. In the case of a late enrollee, coverage begins on the date coverage under the other health plan ends. DSGHP covered students who are eligible for an early effective date of coverage because of a requirement to be at Dartmouth College prior to September 1 (or prior to the beginning of other coverage periods) may also obtain early coverage for their eligible dependents. Early dependent coverage, however, requires payment of an additional premium. Application for this coverage must be submitted to the DSGHP Office prior to the effective date of coverage.

When Student Coverage Ends

Your coverage will end on the earliest of the following dates:

- The next succeeding August 31, if you waive coverage for the next *plan year* or you or your dependents are no longer eligible for the DSGHP coverage.
- The date your Extension of Eligibility program expires if you purchase this program as described below or October 31 for a student who has qualified for Post-Graduation Coverage.
- The date you or your dependent(s) enter into the Armed Services of any country. A pro-rated refund of the premium will be provided for the DSGHP for the covered individual. If you are the individual entering into the Armed Services, your dependents will continue to be eligible for coverage under the DSGHP if, and for so long as, they continue to reside in the United States.
- December 31 or March 31 following your timely submission of an application to cancel your student coverage, pursuant to the following requirements.

You may apply for early cancellation of your student coverage at the end of Fall or Winter Term and obtain a refund of a portion of the premium of your coverage under the DSGHP if you complete your degree requirements or if you withdraw or separate from the College. Your application to cancel coverage must include either a letter from the appropriate Dean certifying completion of your degree requirements or a notice of withdrawal or separation from the Registrar. You may also apply for early cancellation of your coverage if you satisfy the DSGHP waiver requirements according to the conditions described in the DSGHP's waiver application form. Your application to cancel must be submitted in writing and received by the DSGHP on or before the 15th of the cancellation month in order to be effective that month.

- Notwithstanding the foregoing, if a *physician* employed by Dartmouth College Health Services certifies that a student is *totally disabled* on the date coverage under the DSGHP would otherwise end, *Covered Expenses/Services* directly related to the *total disability* (see definition). This extension of benefits due to *total disability* is not provided to DSGHP covered persons who have exercised their option to purchase the DSGHP Extension of Eligibility option.

When Dependent Coverage Ends

- Coverage for your dependents will end on the date your coverage ends or the date the dependent ceases to be an eligible dependent, whichever comes first.
- The date you or your dependent(s) enter into the Armed Services of any country. A pro-rated refund of the premium will be provided for the DSGHP for the covered individual. If you are the individual entering into the Armed Services, your dependents will continue to be eligible for coverage under the DSGHP if, and for so long as, they continue to reside in the United States.

Except as specifically provided above, no refunds for the premium under the DSGHP will be provided.

Extension of Eligibility

There are two Extension of Eligibility provisions under the DSGHP as specified in this section.

1. When coverage under the DSGHP terminates due to graduation, separation, or withdrawal from college, you may purchase an Extension of Eligibility under the DSGHP for the next succeeding six months (September 1 through the last day of February) of the next plan year. This Extension of Eligibility provision does not apply to (1) Students who have DSGHP eligibility under the Post-Graduation Coverage provision or (2) Students who did not have student status immediately preceding the loss of DSGHP eligibility.
2. If you become *totally disabled** or obtain an approved *medical withdrawal* from Dartmouth College, you may purchase the plan for up to one *plan year* after your DSGHP coverage would otherwise terminate.

* Refer also to the extension of benefits provision in the section entitled When Student Coverage Ends. The extension of benefits provision allows students to extend DSGHP coverage for the specific condition causing a total disability without incurring additional DSGHP coverage costs.

You must apply for the Extension of Eligibility and pay the premium for DSGHP coverage within 31 days prior to the start of a plan year or the date you become eligible for an Extension of Eligibility. Students who qualify for Extension of Eligibility under the DSGHP may also purchase DSGHP coverage for their dependents (refer to the section entitled Dependent Eligibility). Please contact the DSGHP Office at the Dartmouth College Health Service for further information concerning the Extension of Eligibility.



Dartmouth Commencement 2013
Photo By: Eli Burakian '00

HOW TO CONTACT OR NOTIFY THE DSGHP

Assistance regarding enrollment, plan benefits, claims procedures, and required notifications is available on-campus during normal business hours at the DSGHP Office.

The DSGHP Assistance Group

On Campus - General Assistance

DSGHP Office

Mailing Address

7 Rope Ferry Road
Hanover NH 03755

Physical Location

37 Dewey Road 4th Floor
Rooms: 403 & 408
Hanover, NH 03755

Phone: 603-646-9438
603-646-9449
Fax: 603-646-8893

Web: dartgo.org/studentinsurance

Email: Dartmouth.Student.Health.Plan@Dartmouth.edu

Claims Administrator/Prior Notification of Hospital Admissions/Pediatric Dental

HealthSmart

3320 West Market St., Suite 100
Fairlawn, OH 44333

Web: <http://www.healthsmart.com/>

Phone: 844-206-0372
330-576-9000
Prior Notification of Hospital Admissions: 877-202-6379
Email: akronclaims@HealthSmart.com

Pharmacy Processor

Express Scripts

ATTN: Commercial Claims
P.O. Box 2872
Clinton, IA 52733-2872

Member Phone: 800-711-0917
Pharmacy Phone: 800-922-1557

PPO Network & Medical Claim Submission

Cigna PPO

PO Box 188061
Chattanooga TN 37422-8062
Web: <http://www.cigna.com>

Phone: 844-206-0372
330-576-9000

Basix Dental Savings Program

web: <http://www.basixstudent.com/>

Emergency Travel Assist Service

International SOS

Web: <http://www.internationalsos.com> & <http://www.dartmouth.edu/~rmi/rmstravel/>

Scholastic Members
Phone: 215-942-8478

Benefits for Services from Dartmouth College Health Service

The DSGHP pays the highest level of benefits for services you receive from Dartmouth College Health Service. In all other instances, the *coinsurance* amount (i.e., the percentage of the *Covered Expenses/Services* that the DSGHP pays) is lower.

For services received from Dartmouth College Health Service, the DSGHP pays 100% of *Covered Expenses/Services* and the *plan year deductible* does not apply. These services are for covered immunizations,* Inpatient Services, Clinic & Physical Exam Visits.

*Immunizations that are (1) not covered by the Prescription Drug benefits of the DSGHP are reimbursed at 80 percent and are not subject to the In-network deductible when administered by a provider at the Dartmouth College Health Service (2) required immunizations under the PPACA, however, are covered at 100 percent.

PPO Network Benefits

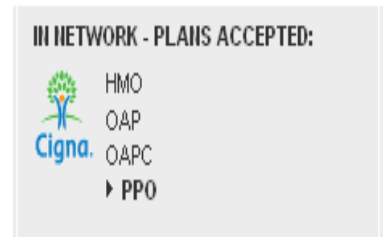
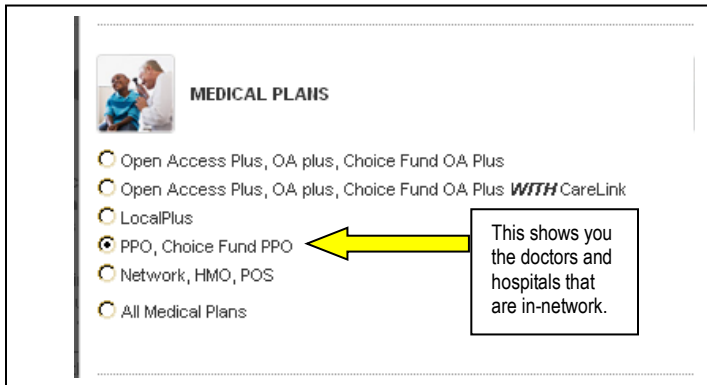
In-network providers are the *physicians, hospitals, and other health care facilities* that have contracted with HealthSmart/Cigna to provide specific medical services at negotiated prices. They are referred to collectively as the PPO Network. Providers in the PPO Network accept the *allowed amount* as full payment for *Covered Expenses/Services* (subject to *deductible, co-payment, and coinsurance* provisions). You identify your eligibility for *in-network* charges by showing your health plan Identification Card to the *provider* when you obtain care.

You should be aware that PPO Network *hospitals* may be staffed with *physicians* and other professional staff who are not in the PPO Network. Unless specified otherwise, the charges of the Non-PPO Providers (out-of-network) will not be paid at the PPO Network level of benefits.

How to find PPO Network Provider

Go to website at: Cigna www.Cigna.com

To find out more about the doctors and services listed in the Cigna directory and click on "Find a Doctor" then [Select a plan for your search](#) (Recommended) and see doctors and facilities that are in-network for your plan.



- Pharmacy Network: Express Scripts:

For more information on *preferred provider* benefits, see the section entitled *Coinsurance*.

Out of Hanover, NH, Area PPO Network Benefits

The DSGHP provides coverage when you receive medical care outside of the *Hanover NH Area* from a PPO Provider. Generally, the percentage of charges that the DSGHP pays is the same as for *Hanover NH Area* PPO Network Provider. The DSGHP, however, does not cover certain services outside of the *Hanover NH Area*, as shown in the Schedule of Benefits.

The lack of available PPO Providers in a specific geographic area may not be used as the basis for an appeal of claim under the DSGHP.

Non-PPO (out-of-network) Network Benefits

You may choose to use a Provider that is not a member of the PPO Network. This will, however, increase your out-of-pocket costs because the DSGHP does not pay as large a portion of non-PPO Network Provider charges. Generally, after you satisfy the increased *deductible*, when applicable, the DSGHP will pay the percentage of *usual and customary charges* shown in the DSGHP Schedule of Benefits for *Covered Expenses/Services* performed by a non-PPO Network Provider.

Plan Year Aggregate Deductible

The *plan year aggregate deductible* is the total amount you must pay for *Covered Expenses/Services* during each *plan year* before the DSGHP will consider *Covered Expenses/Services* for reimbursement. Expenses from separate *illnesses* or *injuries* may be used to satisfy the *deductible*.

The individual *deductible* applies separately to each *covered person*. The family *deductible* applies collectively to all *covered persons* in the same family. When the family *deductible* is satisfied, no further *deductible* payment will be required of any covered family member during the remainder of that *plan year*.

The *plan year* individual and family *deductible* amounts are shown on the Schedule of Benefits. Any amount applied toward the PPO Network Medical Deductible will be applied toward the Non-PPO Medical Deductible and vice versa.

Co-payments

The *co-payment* amounts, as specified in the Schedule of Benefits, represent the dollar amounts required to be paid by the *covered person* for *Covered Expenses/Services* before the *deductible* applies and before the DSGHP pays benefits at the percentage described in the Schedule of Benefits.

Co-insurance

Coinsurance represents the percentage of *Covered Expenses/Services* required to be paid by the DSGHP after satisfaction of any applicable *deductible* or *co-payment* amount.

After satisfaction of any applicable *deductible* or *co-payment*, the DSGHP will pay the percentage of charges indicated in the Schedule of Benefits, subject to the specified maximums. These percentages apply only to *Covered Expenses/Services* which do not exceed *usual and customary charges*. The *covered person* is responsible for all non-*Covered Expenses/Services* and any amount which exceeds the *usual and customary charge* for *Covered Expenses/Services*.

The *coinsurance* percentages for In-Network and Out-of-Network Providers are specified in the Schedule of Benefits. The DSGHP encourages you to use *In-network providers* whenever possible. You will receive a higher level of benefits for services received from *In-network providers*.

In-network providers will not bill you separately if their charges exceed the In-Network fee schedule. You may be billed separately when charges made by an Out-of-Network Provider exceed the *usual and customary charge* for such services.

Charges for services provided by certain Network Hospital - affiliated *physicians* who are *Out-network providers* are eligible for payment at the same percentage as In-Network Provider charges. Such charges are limited to charges for anesthesiologists and emergency room *physicians* and the professional component charges for pathology and radiology. Charges made by a Hospital - affiliated *physician* payment will be reimbursed based on *usual and customary* as determined by the DSGHP.

Out-Of-Pocket Maximums

The *Out-of-Pocket Maximum* is the maximum amount of *Covered Expenses/Services* a *covered person* must pay during a *plan year*. The individual *out-of-pocket maximum* applies separately to each *covered person*. When a *covered person* reaches the *plan year out-of-pocket maximum*, the DSGHP will pay 100% of all additional *Covered Expenses/Services* for that individual during the remainder of the *plan year*. Co-payments, deductibles and Co-insurance are included in the out-of-pocket. The family *out-of-pocket maximum* applies collectively to all *covered persons* in the same family. When the *plan year family out-of-pocket maximum* is reached, the DSGHP will pay 100% of *Covered Expenses/Services* for any covered family member during the remainder of the *plan year*.

The *Out-of-Pocket Maximum* does not apply to the following:

- Any expenses not covered by the DSGHP, including expenses which exceed *usual and customary charges*.
- Charges in excess of Benefit Maximums (see next section).
- Penalties for failure to comply with the Health Care Management Program's prior notification of hospital admission requirements.

The *plan year* individual and family *Out-of-Pocket Maximum* amounts are shown in the Schedule of Benefits. Any amount applied toward the PPO Network *Out-of-pocket maximum* will be applied toward the Non-PPO *Out-of-pocket maximum* and vice versa.

Benefit Maximums

Total plan payments for each *covered person* are limited to certain maximum benefit amounts. A benefit maximum can apply to specific benefit categories or to all benefits. A benefit maximum amount also applies to a specific time period, such as *plan year*, number of visits or *lifetime*.

The benefit maximums applicable to the DSGHP are shown on the Schedule of Benefits. Maximums apply to PPO and Non-PPO Network benefits combined.



Dartmouth ROTC members lower the American Flag on Veteran's Day

Photo By: Eli Burakian '00

2016 - 2017 Dartmouth Student Group Health Plan Benefit Chart

Deductibles & Out-of-Pocket Maximums	In-Network	Out-of-Network
Medical Deductible	\$250 Individual \$500 Family	\$500 Individual \$1,000 Family
Prescription Deductible (Does not apply to Dick's House Pharmacy)	\$50 Individual / \$100 Family	
Medical and Prescription Out-of-Pocket Maximum	\$3,000 Individual \$5,000 Family	\$6,000 Individual \$10,000 Family (of usual and customary charges)
Benefit Description	In-Network	Out-of-Network
	Referral required from Dartmouth College Health Service if in the Hanover, NH area.	
Preventive Care Services (If in Hanover, NH area: Services received at Dartmouth College Health Service, or with referral if services are not available at Dartmouth College Health Service.)	100%	Not Covered
Services at Dartmouth College Health Service (Except for certain medical supplies, durable medical equipment, medical services, and immunizations.)	100%	N/A
Emergency Room Services (Co-payment waived if admitted.)	100% after \$100 co-payment	100% of usual and customary charges after \$100 co-payment
Ambulance	100% after \$100 co-payment	100% of usual and customary charges after \$100 co-payment
Outpatient Mental/Nervous and Substance Abuse Treatment	80%; no deductible	70% of usual and customary charges; no deductible
Inpatient Mental/Nervous and Substance Abuse Treatment	80% after deductible	70% of Usual and Customary charges after deductible
Biologically Based Mental Health Care Services (Benefits are provided on the same basis as any other medical condition.)		
In & Outpatient Services for Physician Expenses (Includes office visits, hospital visits, surgery, diagnostic, X-rays, and laboratory tests.)		
Inpatient Hospital Services		
Home Health Care Services		
Skilled Nursing Facility (limited 100 days)		
Sex Reassignment Surgery (Lifetime limit. Referral from Dartmouth College Health Services is required.)	Covered Medical Expenses are payable on the same basis as any other condition except that surgery for gender reassignment is limited to a lifetime maximum of \$75,000	
Lifetime Individual Maximum for All Benefits (Unless otherwise specified.)	No maximum	
National Collegiate Athletic Association (NCAA) Sanctioned Intercollegiate Sports Injuries	For all NCAA Sanctioned Intercollegiate Sports Injuries, the DSGHP is primary for the first \$90,000 of eligible expense per injury and secondary to coverage provided under the NCAA catastrophic policy.	
Club Sports Injuries	For all Club Sports Injuries, the DSGHP is primary for the first \$30,000 of eligible expense per injury and secondary to coverage provided under the Club Sport catastrophic policy.	

Pharmacy Benefit Description	In-Network	Out-of-Network
Dick's House Pharmacy at Dartmouth College Health Service (Not subject to prescription plan year deductible. \$5 Generic drug copayment per 30 day prescription, \$15 brand name drug copayment per 30 day prescription, 100% coverage for generic contraception medication and medically necessary brand name contraception medication. If receiving a 90 day supply, there will be a \$10 copayment for generic drugs, and a \$30 copayment for brand name drugs.)	N/A	
Other Pharmacies	80% Express Scripts participating pharmacies, 100% coverage (not subject to prescription plan year deductible) for generic contraception medication and medically necessary brand name contraception medication	80% of usual and customary charges
Dispensing Limits: The amount of drug which may be dispensed per prescription or refill (regardless of dosage form) is limited to a 90 day supply. Other dispensing limits may be imposed as required by federal or state regulation for other reasons.		

1. The *coinsurance* amount applicable to non-emergency medical services received by you, your spouse, or your domestic partner in the *Hanover NH Area* will be reduced to the out-of-network level (70%) if a referral for such services was not first obtained from the Dartmouth College Health Service. This reduction will not apply to services received by your dependent children, to expenses incurred outside of the *Hanover NH Area* or to maternity expenses.

A recommendation by a non-Health Service Provider for follow-up care does not meet the DSGHP's referral requirement. Services received within 45 days following the *medically necessary* use of an emergency room are not subject to the referral requirement for the DSGHP. This waives the referral requirement that only applies to services related to the condition requiring an emergency room visit. After the 45 day period, a referral is required from the Dartmouth College Health Service.

2. These services are subject to the Health Care Management Program. If you do not follow the procedures required for prior notification of hospital admission, the *coinsurance* amount applicable to all related eligible expenses will be reduced to 50%. The penalty for failure to give prior notification of hospital admission does not count towards your *out-of-pocket maximum*.

To contact the Health Care Management Program, call toll-free 877-202-6379.

PPACA PREVENTIVE CARE BENEFITS

Preventive Care Benefits are provided by the DSGHP benefits in full compliance with the Patient Protection and Affordable Care Act (PPACA). Such PPACA preventive care benefits must be obtained at Dartmouth College Health Services if the service or supply is available at Dartmouth College Health Services. This limitation does not apply for services rendered at an *in-network provider* if:

- 1) The service or supply is not within the scope of services provided by Dartmouth College Health Services;
- 2) The student receives the service or supply in or outside of the *Hanover NH Area*; or
- 3) The DSGHP-covered person is not eligible to obtain the service or supply from the Dartmouth College Health Service.

PPACA Preventive Care Benefits are provided at 100% percent reimbursement as specified in the Schedule of Benefits for services received at Dartmouth College Health Services and services received at *in-network providers* as specified in this section.

The DSGHP also provides certain preventive care benefits and services that exceed requirements of the PPACA; these benefits and services are provided in the section entitled Covered Services/Expenses, and are provided pursuant to the Schedule of Benefits.

PPACA Preventive Care Benefits are subject to change, pursuant to determinations by the [U.S. Department of Health and Human Services](#) and the [U.S. Preventive Services Task Force](#). Refer to the DSGHP web site for updates.

Covered Preventive Services for Adults

1. [Abdominal aortic aneurysm one-time screening](#) for men of specified ages who have ever smoked
2. [Alcohol misuse screening and counseling](#)
3. [Aspirin use](#) to prevent cardiovascular disease for men and women of certain ages
4. [Blood pressure screening](#)
5. [Cholesterol screening](#) for adults of certain ages or at higher risk
6. [Colorectal cancer screening](#) for adults over 50
7. [Depression screening](#)
8. [Diabetes \(Type 2\) screening](#) for adults with high blood pressure
9. [Diet counseling](#) for adults at higher risk for chronic disease
10. [Falls prevention](#) in order adults (exercise or physical therapy)
11. [Falls prevention](#) in older adults (vitamin D)
12. [Hepatitis B screening](#) for people at high risk, including people from countries with 2% or more Hepatitis B prevalence, and U.S.-born people not vaccinated as infants and with at least one parent born in a region with 8% or more Hepatitis B prevalence.
13. [Hepatitis C screening](#) for adults at increased risk, and one time for everyone born 1945 – 1965
14. [HIV screening](#) for everyone ages 15 to 65, and other ages at increased risk
15. [Immunization vaccines](#) for adults — doses, recommended ages, and recommended populations vary:
 - [Diphtheria](#)
 - [Hepatitis A](#)
 - [Hepatitis B](#)
 - [Herpes Zoster](#)
 - [Human Papillomavirus \(HPV\)](#)
 - [Influenza \(flu shot\)](#)
 - [Measles](#)
 - [Meningococcal](#)

Continued Covered Preventive Services for Adults

- Mumps
 - Pertussis
 - Pneumococcal
 - Rubella
 - Tetanus
 - Varicella (Chickenpox)
16. Lung cancer screening for adults 55 - 80 at high risk for lung cancer because they're heavy smokers or have quit in the past 15 years
 17. Obesity screening and counseling
 18. Sexually transmitted infection (STI) prevention counseling for adults at higher risk
 19. Skin Cancer Behavioral Counseling
 20. Syphilis screening for adults at higher risk
 21. Tobacco Use screening for all adults and cessation interventions for tobacco users

Services for Pregnant Women or Women who may become Pregnant

1. Anemia screening on a routine basis
2. Breastfeeding comprehensive support and counseling from trained providers, and access to breastfeeding supplies, for pregnant and nursing women
3. Contraception: Food and Drug Administration-approved contraceptive methods, sterilization procedures, and patient education and counseling, as prescribed by a health care provider for women with reproductive capacity (not including abortifacient drugs). This does not apply to health plans sponsored by certain exempt "religious employers." [Learn more about contraceptive coverage.](#)
4. Folic acid supplements for women who may become pregnant
5. Gestational diabetes screening for women 24 to 28 weeks pregnant and those at high risk of developing gestational diabetes
6. Gonorrhea screening for all women at higher risk
7. Hepatitis B screening for pregnant women at their first prenatal visit
8. Rh Incompatibility screening for all pregnant women and follow-up testing for women at higher risk
9. Syphilis screening
10. Expanded tobacco intervention and counseling for pregnant tobacco users
11. Urinary tract or other infection screening

Other Covered Preventive Services for Women

1. Breast cancer genetic test counseling (BRCA) for women at higher risk
2. Breast cancer mammography screenings every 1 to 2 years for women over 40
3. Breast cancer chemoprevention counseling for women at higher risk

Continued Covered Preventive Services for Women

4. Cervical cancer screening for sexually active women
5. Chlamydia infection screening for younger women and other women at higher risk
6. Domestic and interpersonal violence screening and counseling for all women
7. Gonorrhea screening for all women at higher risk
8. HIV screening and counseling for sexually active women
9. Human Papillomavirus (HPV) DNA test every 3 years for women with normal cytology results who are 30 or older
10. Osteoporosis screening for women over age 60 depending on risk factors
11. Rh incompatibility screening follow-up testing for women at higher risk
12. Sexually transmitted infections counseling for sexually active women
13. Syphilis screening for women at increased risk
14. Tobacco use screening and interventions
15. Well-woman visits to get recommended services for women under 65

Covered Preventive Services for Children

1. Alcohol and drug use assessments for adolescents
2. Autism screening for children at 18 and 24 months
3. Behavioral assessments for children ages: 0 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years
4. Blood pressure screening for children ages: 0 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years
5. Cervical dysplasia screening for sexually active females
6. Depression screening for adolescents
7. Developmental screening for children under age 3
8. Dyslipidemia screening for children at higher risk of lipid disorders ages: 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years
9. Fluoride chemoprevention supplements for children without fluoride in their water source
10. Gonorrhea preventive medication for the eyes of all newborns
11. Hearing screening for all newborns
12. Height, weight and body mass index (BMI) measurements for children ages: 0 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years
13. Hematocrit or hemoglobin screening for all children
14. Hemoglobinopathies or sickle cell screening for newborns
15. Hepatitis B screening for adolescents at high risk, including adolescents from countries with 2% or more Hepatitis B prevalence, and U.S.-born adolescents not vaccinated as infants and with at least one parent born in a region with 8% or more Hepatitis B prevalence: 11 – 17 years.
16. HIV screening for adolescents at higher risk
17. Hypothyroidism screening for newborns

18. **Immunization vaccines** for children from birth to age 18 — doses, recommended ages, and recommended populations vary:
 - Diphtheria, Tetanus, Pertussis (Whooping Cough)
 - Haemophilus influenzae type b
 - Hepatitis A
 - Hepatitis B
 - Human Papillomavirus (PVU)
 - Inactivated Poliovirus
 - Influenza (flu shot)
 - Measles
 - Meningococcal
 - Pneumococcal
 - Rotavirus
 - Varicella (Chickenpox)
19. **Iron supplements** for children ages 6 to 12 months at risk for anemia
20. **Lead screening** for children at risk of exposure
21. **Medical history** for all children throughout development ages: 0 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years
22. **Obesity screening and counseling**
23. **Oral health risk assessment** for young children ages: 0 to 11 months, 1 to 4 years, 5 to 10 years
24. **Phenylketonuria (PKU) screening** for newborns
25. **Sexually transmitted infection (STI) prevention counseling and screening** for adolescents at higher risk
26. **Tuberculin testing** for children at higher risk of tuberculosis ages: 0 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years
27. **Vision screening** for all children



The Dartmouth Green at sunset
Photo By: Joseph Mehling '69

MEDICAL BENEFITS AND REQUIREMENTS

General Requirements

You will get the most out of the benefits provided by the DSGHP by understanding the following requirements.

1. To obtain the maximum amount of benefits for non-emergency services in the *Hanover NH Area* for you, your covered spouse, or your *domestic partner*, you must obtain a written referral from the Dartmouth College Health Services. These requirements do not apply to your dependent children, to expenses incurred outside of the *Hanover NH Area*, or to maternity expenses.
2. The referral from the Dartmouth College Health Service must be reauthorized within 30 days unless otherwise specified by either (1) the Dartmouth College Health Service clinicians providing services to the DSGHP-covered student/spouse or (2) a specific exception authorizing a longer referral period as specified in other provisions of this *Plan Document*.
3. The *coinsurance* amount applicable to non-emergency medical services received by you, your spouse, or your domestic partner in the *Hanover NH Area* will be reduced to the out-of-network level (70%) if a referral for such services was not first obtained from the Dartmouth College Health Service. This reduction will not apply to services received by your dependent children, to expenses incurred outside of the *Hanover NH Area* or to maternity expenses.
4. The DSGHP will cover testing for learning disabilities and benefits are payable the same as any other major medical expense both inside and outside the *Hanover NH Area*. Refer to *Covered Expenses/Services* for details.
5. The DSGHP will not cover sleep testing and sleep disorders unless a referral is made by Dartmouth College Health Service. This benefit is provided only in the *Hanover NH Area*.
6. To obtain the maximum amount of benefits for elective admissions to a *hospital, hospice facility, or skilled nursing facility*, and before receiving any *home health care* or *home hospice* services, you must notify the DSGHP as described under the Health Care Management Program's prior notification of hospital admission requirement.
7. The DSGHP provides benefits only for *Covered Expenses/Services* that are *medically necessary* for the treatment of a covered *illness or injury*. Not all *medically necessary* services are covered. For example, *experimental/investigational* treatments are not covered. See the section on *Excluded Expenses/Services* for a listing of those expenses/services that are excluded by the DSGHP.
8. The DSGHP provides benefits only for *Covered Expenses/Services* that are equal to or less than the *usual and customary charge* in the geographic area where services or supplies are provided. Any amounts that exceed the *usual and customary charge* are not recognized by the DSGHP for any purpose. PPO Network Providers charge the DSGHP for their services at negotiated rates which are considered to be the usual and customary charge for those services. If you use a non-PPO Network Provider, you will be responsible for any amounts in excess of the *usual and customary charge*. The *deductible* and *coinsurance* is also increased for Non-PPO-Network Provider services.
9. The DSGHP provides benefits only for covered services and supplies rendered by a *physician, practitioner, nurse, hospital, or specialized treatment facility* as those terms are specifically defined in the Definitions section.

Health Care Management Program

The DSGHP employs the services of a professional Health Care Management Program company to identify and assist participants with conditions requiring extensive or long-term care.

The DSGHP's Health Care Management Program is not intended to diagnose or treat medical conditions, guarantee benefits, validate eligibility, or determine *medical necessity* unless a special care manager is assigned. A case manager may be assigned in situations regarding *medical necessity*.

Prior Notification of Hospital Admission Requirements – Elective and Emergency Admissions

You must call HealthSmart's toll-free number (877-202-6379) before any elective admission to a hospital, hospice facility, or skilled nursing facility, and before receiving any home health care or home hospice services. You must also call within 48 hours (2 working days) following any emergency admission. When you call, it will be necessary to provide your name as the subscriber, the patient's name, the name of the physician and hospital or facility, the reason for the hospitalization, and any other information needed to complete the process.

In the event of pregnancy, notification is not required at the time of admission for a delivery—but notification is required when additional days in the hospital would extend beyond the number of inpatient days necessary after a delivery.

A recommendation by a non-Health Service Provider for follow-up care does not meet the DSGHP's referral requirement. Services received within 45 days following the medically necessary use of an emergency room are not subject to the referral requirement for the DSGHP. This waiver of the referral requirement only applies to services related to the condition requiring an emergency room visit. After the 45 day period, a referral is required from the Dartmouth College Health Service.

Reduced Benefits for Failure to Follow Required Prior Notification Procedure

If you do not follow the DSGHP's Pre-Admission Certification Requirement Prior Notification Procedure described above, the DSGHP will cover only 50% of all related eligible expenses. This is in addition to any applicable *deductible* amount that you are required to pay. The penalty for failing to follow the Prior Notification Requirement procedures does not count toward your *out-of-pocket maximum*.

Medical Case Management

Medical Case Management is designed to help manage the care of patients who have special or extended care *illnesses or injuries*. The primary objective of Medical Case Management is to identify and coordinate cost-effective medical care alternatives meeting accepted standards of medical practice. Medical Case Management also monitors the care of the patient, offers emotional support to the family, and coordinates communications among *health care providers*, patients, and others.

When you call the DSGHP's Health Care Management Program as required, the type of care you receive will be monitored by a health care professional. If appropriate, you will be assigned a case manager who will assist you in examining your health care alternatives.

Based on the advice of the DSGHP's Health Care Management Program, benefits may be modified by the DSGHP *Administrator* to permit a method of treatment not expressly provided for, but not prohibited by law, rules, or public policy, if the DSGHP *Administrator* determines that such modification is *medically necessary* and is more cost-effective than continuing a benefit to which you or your eligible dependents may otherwise be entitled. The DSGHP *Administrator* also reserves the right to limit payment for services to those amounts which would have been charged had the service been provided in the most cost-effective setting in which the service could safely have been provided.

Examples of *illnesses or injuries* that may be appropriate for Medical Case Management include, but are not limited to:

- Chronic or Terminal *illnesses* such as AIDS, cancer, multiple sclerosis, renal failure, chronic obstructive pulmonary disease, and cardiac conditions.
- Post-*accident* long-term rehabilitative therapy
- Newborns with high risk complications or multiple birth defects.
- Diagnosis involving long-term IV therapy.
- Child and adolescent mental/nervous disorders.
- Illnesses not responding to medical care.

Chemical/ Substances Abuse Case Management

Pre-authorization for inpatient and *outpatient* care for chemical/substance abuse treatment is subject to the Dartmouth College Health Services referral requirement. There are no other pre-certification or case management requirements or services for chemical/substance care.

COVERED EXPENSES/SERVICES

When all of the provisions of the DSGHP are satisfied, the DSGHP will provide benefits as specified in the Schedule of Benefits for the *medically necessary* services and supplies listed in this section.

Treatment or services rendered outside the United States of America or its territories are covered on the same basis as treatment or services rendered within the United States (refer also to the section entitled Travel Outside of the United States).

Emergency Services

1. Ground transportation provided by a professional ambulance service to an emergency care facility equipped to treat a *medical emergency*.
2. Treatment of a *medical emergency* (illness or injury) in a hospital emergency room (see schedule of benefits for co-payment benefit).
3. Treatment of a *medical emergency* (illness or injury) in an urgent care facility or other stand-alone emergency care facility.

Diagnostic X-ray and Laboratory Services

1. Amniocentesis.
2. Computerized Axial Tomography (CAT Scan).
3. *Diagnostic charges* for laboratory services.
4. *Diagnostic charges* for X-rays.
5. Dual Energy X-ray Absorptiometry (DEXA Scan).
6. Magnetic Resonance Imaging (MRI).
7. Mammography screening per the schedule shown in the section entitled Preventive Care Benefits.
8. Positron Emission Tomography (PET Scan).
9. Pre-admission tests (PAT) for a *hospital* admission.
10. Prostate Specific Antigen (PSA) screening, payable as preventive care Services in the schedule of benefits chart
11. Ultrasound.

Hospital Services

1. *Intensive care unit* and coronary care unit charges.
2. Miscellaneous *hospital* services and supplies required for treatment during a *hospital* confinement.
3. *Outpatient hospital* services.
4. Private room and board, not to exceed the cost of a semi-private room (if available).
5. Semi-private room and board.
6. Well-baby nursery, *physician*, and initial exam expenses during the initial *hospital* confinement of a newborn. Charges for the newborn will be considered as part of the mother's expenses.

A statement is required from the prescribing *physician* describing how long the equipment is expected to be necessary. This statement will determine whether the equipment will be rented or purchased.

Medical Equipment and Supplies

1. Artificial limbs and eyes and replacement of artificial eyes and limbs if required due to a change in the patient's physical condition; or replacement, if replacement is less expensive than repair of existing equipment.
2. Blood and/or plasma and the equipment for its administration.
3. Compression therapy garments (e.g., Jobst garments).
4. *Durable medical equipment*, including expenses related to necessary repairs and maintenance.
5. Enteral Formula and modified low protein food products. (enteral pumps and related equipment and supplies)
6. Initial prescription contact lenses or eyeglasses, including the examination and fitting of the lenses, to replace the human lens lost through *intraocular surgery*. Also covered are medical necessary contact lenses for the following conditions: Keratoconus. • Aphakia. • Anisometropia • Aniseikonia. • Pathological Myopia. • Aniridia. • Corneal Disorders. • Post-Traumatic Disorders. • Irregular Astigmatism.
7. Insulin infusion pumps.
8. Original fitting, adjustment, and placement of orthopedic braces, casts, splints, crutches, cervical collars, head halters, traction apparatus, or prosthetic appliances to replace lost body parts or to aid in their function when impaired. Replacement of such covered devices only will be covered if the replacement is necessary due to a change in the physical condition of the *covered person*.
9. Orthotics, orthopedic or corrective shoes, and other supportive appliances for the feet.
10. Oxygen and rental of equipment required for its use, not to exceed the purchase price of such equipment.
11. Sterile surgical supplies after *surgery*.
12. Wigs and artificial hairpieces, only after chemotherapy or radiation therapy, or when it is disease- or *injury*-related and not due to the normal aging process or premature baldness.
13. Breast Pump

Medical Services

1. Acupuncture.
2. Allergy testing and treatment, including allergy sera.
3. **Cardiac Rehabilitation.** Benefits are available for Outpatient cardiac rehabilitation programs. Covered Services are: exercise and education under the direct supervision of skilled program personnel in the intensive rehabilitation phase of the program. The program must start within three months after a cardiac condition is diagnosed or a cardiac procedure is completed. The program must be completed within six months of the cardiac diagnosis or procedure.

No Benefits are available for portions of a cardiac rehabilitation program extending beyond the intensive rehabilitation phase. On-going or life-long exercise and education maintenance programs intended to maintain fitness or to reinforce permanent lifestyle changes are not covered, even if ordered by your physician or supervised by skilled program personnel.

4. Chemotherapy, including high-dose chemotherapy in connection with autologous bone marrow transplantation, stem cell rescue, or other hematopoietic support procedures for treatment of acute leukemia in remission, resistant non-Hodgkin's lymphoma, Hodgkin's disease, neuroblastoma, Ewing's sarcoma, multiple myeloma (after induction therapy), and non-inflammatory stage II breast cancer with 10 or more positive nodes and negative bone marrow, but only when the individual qualifies as a candidate for the procedure under the health and age standards generally accepted by the national medical professional community.

Other courses of treatment involving high-dose radiotherapy and autologous bone marrow transplantation, stem cell rescue, or other hematopoietic support procedures for any symptom, disease, or condition are not covered.

5. *Chiropractic services.*
6. Dental services received after an *accidental injury* to teeth, excluding biting or chewing *injuries*. This includes replacement of teeth and any related X-rays.
7. Dialysis.
8. **Early Intervention Services.** Benefits for early intervention services are available for covered persons from birth to the child's third birthday. Benefits are available to those with significant functional physical or mental deficits due to a developmental disability or delay. Covered Services include Medically Necessary physical, speech/language and occupational therapy, nursing care, and psychological counseling provided by behavioral health providers, such as Clinical Social Workers. Physical, speech and occupational therapy visits do not count toward any annual limits that may apply.
9. **Infusion Therapy.** Benefits are available for Medically Necessary home infusion therapy furnished by a licensed infusion therapy provider. Covered Services are:

Home nursing services for intravenous antibiotic therapy, chemotherapy or parenteral nutrition therapy, Antibiotics, chemotherapy agents, medications and solutions used for parenteral nutrients, Associated supplies and portable, stationary or implantable infusion pumps.

10. **Infertility Diagnostic Services.** Benefits are available for diagnostic services to determine the cause of medically documented infertility. For the purposes of determining Benefit availability, "infertility" is defined as the diminished or absent capacity to create a pregnancy. Infertility may occur in either a female or a male.

Infertility may be suspected when a presumably healthy woman who is trying to conceive does not become pregnant after her uterus has had contact with sperm during 12 ovulation cycles in a period of up to 24 consecutive months, as medically documented. For women over age 35, infertility may be suspected after a woman's uterus has had contact with sperm during six ovulation cycles in a period of up to 12 consecutive months, as medically documented.

The Plan may waive the applicable time limits when the cause of infertility is known and medically documented. Please note that menopause in a woman is considered a natural condition and is not considered "infertility" for the purposes of determining Benefit availability under this health plan.

To be eligible for Benefits, treatment must be Medically Necessary and furnished by an obstetrical/gynecological specialist.

Covered Services. Benefits are available for the following Covered Services to determine the cause of medically documented infertility:

Medical exams, Laboratory tests, including sperm counts and motility studies, sperm antibody tests, cervical mucus penetration tests, surgical procedures, and Ultrasound and other imaging exams, such as hysterosalpingography to determine the cause of infertility or to establish tubal patency.

Covered Services may be provided to male or female covered persons. Coverage is not available to partners who are not covered persons. Benefits for are subject to cost sharing amounts for medical exams, laboratory and x-ray tests, surgery and anesthesia.

Limitations and Exclusions. Except as stated above, no benefits are available under the terms of this Plan for any service to diagnose or treat infertility or for any care (Inpatient or Outpatient) related to a non-covered service.

No Benefits are available under any portion of this Plan for the following services or for any care related to these services: Medical exams, consultations and surgical procedures to treat or correct the cause of infertility or to treat or correct medical conditions contributing to infertility, Male or female fertility drugs and hormones, and any service to prescribe or monitor the use of fertility drugs or hormones, Medical care, sonograms (ultrasounds), laboratory services, radiological services or any other service related to treatment of infertility, Egg or sperm procurement, harvesting or processing (including donor services), egg or sperm banking, storage or, microfertilization (egg drilling or tweaking) and electroejaculation procedures, Intracervical or intrauterine (IUI) artificial insemination (AI), using the partner's sperm (AIH) or donor sperm (AID), Assisted reproduction technology (ART) such as intravaginal culture, in-vitro fertilization and embryo transfer (IVF-ET) such as natural oocyte retrieval (NORIF or NORIVF), gamete intrafallopian transfer (GIFT), zygote intrafallopian transfer (ZIFT), Cryopreservation of donor eggs, cryopreservation of embryos or cryopreserved embryo transfer (CET), intracytoplasmic sperm

injection (ICSI), preimplantation genetic diagnosis (PGD), To be eligible for Benefits, neither partner can have undergone a previous voluntary or elective sterilization procedure. No Benefits are available for services to reverse voluntarily induced sterility or for diagnosis or treatment following the sterilization or sterilization reversal (successful or unsuccessful), Any services or supplies provided to a person not covered under this Plan in connection with a surrogate pregnancy (including the bearing of a child by another woman for an infertile couple), Sex selection, genetic engineering, sperm penetration assays, microvolume straw technique, hamster penetration test (SPA), Any infertility procedure performed during an operation not related to an infertility diagnosis, Culture and fertilization of oocytes, co-culture of embryos and assisted embryo hatching, Direct intraperitoneal insemination (DIPI), peritoneal ovum and sperm transfer (POST), Costs related to donor eggs for or from women with genetic oocyte defects, or donor sperm for or from men with genetic sperm defects, Supplies (such as thermometers and kits to predict ovulation), Menopause in a woman is considered a natural condition and is not considered to be infertility, as defined above. No Benefits are available for infertility diagnosis, procedures or treatment for a woman who is menopausal or perimenopausal (or for their male partners), unless the woman is experiencing menopause at a premature age. Except as stated in this subsection, no Benefits are available for any services to diagnose the cause of infertility or to treat infertility. No Benefits are available for any service that is experimental. No Benefits are available for any service that is not Medically Necessary.

11. *Home health care provided by a home health care agency.*
12. *Home hospice.*
13. Hormone replacement therapy for peri- and post-menopausal women and hormone therapy for the treatment of gender identity disorders.
14. *Inpatient visits by the attending physician.*
15. Intrauterine devices (IUDs), diaphragms, and other medically approved prescription birth control devices that are not covered by the Prescription Drug benefits of the DSGHP. These covered expenses are not subject to the In-network deductible and are reimbursed at 100 percent when provided by Dartmouth College Health Services or when the service or supply is received when the DSGHP is away from the *Hanover NH Area*.
16. Learning disability testing expenses for Students, and their DSGHP Covered Spouses/Domestic Partners for the diagnosis of a learning disorder, are available within the *Hanover NH Area* only upon referral by either Dartmouth College Health Services, Dartmouth College Student Accessibility Services, or Geisel School of Medicine at Dartmouth Office for Learning Disability Services (OLADS). Such learning disability testing for Students, and their DSGHP Covered Spouses/Domestic Partners is covered without the referral requirement when obtained outside the *Hanover NH Area*. Benefits are payable the same as any other major medical expense both inside and outside the *Hanover NH Area*.
17. Services for treatment of Attention Deficit Disorder (ADD) or Attention Deficit Hyperactivity Disorder (ADHD) for Students and their DSGHP Covered Spouses/Domestic Partners. Referral requirement maintained in the *Hanover NH Area* only made by either Dartmouth College's Student Accessibility Services, Geisel School of Medicine at Dartmouth Office or Dartmouth College Health Services. Benefits are payable the same as any other major medical expense both inside and outside the *Hanover NH Area*.
18. Learning disability testing expenses for DSGHP Covered Children, the diagnosis of a learning disorder and services for treatment for learning disabilities, including Attention Deficit Disorder (ADD) or Attention Deficit Hyperactivity Disorder (ADHD), are covered expenses. No referral is required for such services for DSGHP Covered Children from either Dartmouth College Health Services, Dartmouth College Student Accessibility Services or Geisel School of Medicine at Dartmouth Office for Learning Disability Services (OLADS). Benefits are payable the same as any other major medical expense both inside and outside the *Hanover NH Area*.
19. Treatment for learning disabilities, including Attention Deficit Disorder (ADD) or Attention Deficit Hyperactivity Disorder (ADHD), for such children may be provided by any *Health Care Provider, Physician, or Provider/Practitioner* specified in the *Plan Document* for the DSGHP. Such services are not available for DSGHP-covered dependent children at Dartmouth College Health Services, Dartmouth College Student Accessibility Services or Geisel School of Medicine at Dartmouth Office for Learning Disability Services (OLADS). Benefits are payable the same as any other major medical expense both inside and outside the *Hanover NH Area*.
20. *Medically necessary* treatment of the feet, including treatment of metabolic or peripheral vascular disease.
21. Non-custodial services of a *nurse* which are not billed by a *home health care agency*.
22. Non-surgical treatment of *morbid obesity*.
23. Non-surgical treatment of temporomandibular joint dysfunction (TMJ).

24. Occupational therapy to restore a physical function or for rehabilitative therapy.
25. Routine vision examinations from an optometrist or ophthalmologist payable as preventive care services in the schedule of benefits charts (one exam each plan year for covered persons 18 years old and younger; one exam every two years for covered persons 19 years old and older.)
26. Physical therapy from a qualified *practitioner*, for restorative or rehabilitative therapy.
27. *Physician* home and office visits.
28. Pregnancy-related care.
29. Routine hearing exams to determine the need for hearing correction or hearing aids payable as preventive care services in the schedule of benefits charts (one exam each plan year for covered persons 18 years old and younger; one exam every two years for covered persons 19 years old and older.)
30. Radiation therapy, including high-dose radiotherapy in connection with autologous bone marrow transplantation, stem cell rescue, or other hematopoietic support procedures for treatment of acute leukemia in remission, resistant non-Hodgkin's lymphoma, Hodgkin's disease, neuroblastoma, Ewing's sarcoma, multiple myeloma (after induction therapy), and non-inflammatory stage II breast cancer with 10 or more positive nodes and negative bone marrow, but only when the individual qualifies as a candidate for the procedure under the health and age standards generally accepted by the national medical professional community.

Other courses of treatment involving high-dose chemotherapy and autologous bone marrow transplantation, stem cell rescue, or other hematopoietic support procedures for any symptom, disease, or condition are not covered.

31. *Second and/or Third surgical opinions.*
32. Clinical Trials;

Benefits are available for routine patient care costs incurred during participation in a qualifying clinical trial for the treatment of:

- Cancer or other life-threatening disease or condition. For purposes of this benefit, a life threatening disease or condition is one from which the likelihood of death is probable unless the course of the disease or condition is interrupted;
- Cardiovascular disease (cardiac/stroke) which is not life threatening, for which a clinical trial meets the qualifying clinical trial criteria stated below;
- Surgical musculoskeletal disorders of the spine, hip and knees, which are not life threatening, for which a clinical trial meets the qualifying clinical trial criteria stated below; and
- Other diseases or disorders which are not life threatening for which a clinical trial meets the qualifying clinical trial criteria stated below.

Benefits include the reasonable and necessary items and services used to prevent, diagnose and treat complications arising from participation in a qualifying clinical trial.

Benefits are available only when the Covered Person is clinically eligible for participation in the qualifying clinical trial as defined by the researcher.

Routine patient care costs for qualifying clinical trials include:

- Covered Health Services for which Benefits are typically provided absent a clinical trial;
- Covered Health Services required solely for the provision of the investigational item or service, the clinically appropriate monitoring of the effects of the item or service, or the prevention of complications; and
- Covered Health Services needed for reasonable and necessary care arising from the provision of an Investigational item or service.

Routine costs for clinical trials do not include

- The Experimental or Investigational Service or item. The only exceptions to this are:
 - Certain Category B devices;
 - Certain promising interventions for patients with terminal illnesses; and

- Other items and services that meet specified criteria in accordance with the Plan's medical and drug policies;
 - Items and services provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient;
 - A service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis; and
 - Items and services provided by the research sponsors free of charge for any person enrolled in the trial.

With respect to cancer or other life-threatening diseases or conditions, a qualifying clinical trial is a Phase I, Phase II, Phase III, or Phase IV clinical trial that is conducted in relation to the prevention, detection or treatment of cancer or other life-threatening disease or condition and which meets any of the following criteria in the bulleted list below.

With respect to cardiovascular disease or musculoskeletal disorders of the spine and hip and knees and other diseases or disorders which are not life-threatening, a qualifying clinical trial is a Phase I, Phase II, or Phase III clinical trial that is conducted in relation to the detection or treatment of such non-life-threatening disease or disorder and which meets any of the following criteria in the bulleted list below.

- Federally funded trials. The study or investigation is approved or funded (which may include funding through in-kind contributions) by one or more of the following:
 - *National Institutes of Health (NIH)*. (Includes *National Cancer Institute (NCI)*);
 - *Centers for Disease Control and Prevention (CDC)*;
 - *Agency for Healthcare Research and Quality (AHRQ)*;
 - *Centers for Medicare and Medicaid Services (CMS)*;
 - A cooperative group or center of any of the entities described above or the *Department of Defense (DOD)* or the *Veterans Administration (VA)*;
 - A qualified non-governmental research entity identified in the guidelines issued by the *National Institutes of Health* for center support grants; or
 - The *Department of Veterans Affairs*, the *Department of Defense* or the *Department of Energy* as long as the study or investigation has been reviewed and approved through a system of peer review that is determined by the *Secretary of Health and Human Services* to meet both of the following criteria:
 - Comparable to the system of peer review of studies and investigations used by the *National Institutes of Health*; and
 - Ensures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.
- The study or investigation is conducted under an investigational new drug application reviewed by the Food and Drug Administration under 42 U.S.C. § 300gg-8(d)(1)(B); and
- The study or investigation is a drug trial that is exempt from having such an investigational new drug application under 42 U.S.C. § 300gg-8(d)(1)(C).

33. Speech therapy from a qualified *practitioner* to restore speech loss due to an *illness, injury*, or surgical procedure, or for rehabilitative therapy.
34. Termination of pregnancy.
35. Titer when *medically necessary* and not for routine testing.
36. Treatment of complications arising from any non-covered *surgery* or procedure.
37. Treatment of diabetes including diabetic education.
38. Treatment of sleep disorders and sleep studies but only in the *Hanover NH Area* with a referral from the Dartmouth College Health Service.

Mental/Nervous and Chemical/Substance Abuse Services

1. Bereavement counseling.
2. *Biologically Based Mental Illnesses*.
3. *Inpatient* treatment of chemical/substance abuse and/or a *mental/nervous disorder*.

4. Marital, couples, and family counseling.
5. *Outpatient* treatment of chemical/substance abuse and/or a *mental/nervous disorder*.
6. *Partial hospitalization* (applies to *inpatient* benefits as a half day).
7. Treatment of or related to an eating disorder.
8. Treatment of or related to an overdose of drug or medication.

Specialized Treatment Facilities

1. *A birthing center*.
2. *A chemical dependency/substance abuse day treatment facility*.
3. A Christian Science sanitarium.
4. *A hospice facility*.
5. *A mental/nervous treatment facility*.
6. *A psychiatric day treatment facility*.
7. *A rehabilitation facility*.
8. *A skilled nursing facility*, pursuant to the limits specified in the Schedule of Benefits.
9. *A substance abuse treatment facility*.
10. *An ambulatory surgical facility*.

Surgical Services

1. Anesthetic services, when performed by a licensed anesthesiologist or certified registered *nurse* anesthetist in connection with a surgical procedure.
2. Assistant surgeon's expenses.
3. Breast augmentation surgery (mammoplasty) and mastectomy, including hormone therapy, for the treatment of gender identity disorders. For you to receive this coverage, the DSGHP covered provider must send the verification to DSGHP Claim Administrator indicating that you are eligible for these covered services. Contact the DSGHP office for questions about how to receive these benefits. No benefits are provided for services and procedures that are considered to be cosmetic services. For example, cosmetic services that may be used to make a person look more feminine include (but are not limited to), procedures such as plastic surgery of the nose, face lift, lip enhancement, facial bone reduction, plastic surgery of the eyelids, liposuction of the waist, reduction of the thyroid cartilage, hair removal, hair transplants, and surgery of the larynx including shortening of the vocal cords. Cosmetic services that may be used to make a person look more masculine include (but are not limited to) procedures such as chin implants, nose implants, and lip reduction.

In the case of a participant who is receiving benefits in connection with a mastectomy and who elects breast reconstruction in connection with such mastectomy, coverage for:

1. all stages of reconstruction of the breast on which the mastectomy has been performed;
 2. surgery and reconstruction of the other breast to produce a symmetrical appearance;
 3. and, prostheses and physical complications of mastectomy, including lymphedemas; in a manner determined in consultation with the attending physician and the patient.
4. Circumcision for newborns.

5. Human organ and tissue transplants, including Allogeneic (HLA identical match) bone marrow transplants for acute leukemia, advance Hodgkin's lymphoma, advance non-Hodgkin's lymphoma advance neuroblastoma (for children who are at least one year old), aplastic anemia, chronic myelogenous leukemia, infantile malignant osteoporosis, severe combined immunodeficiency, Thalassemia major and Wiskott-Aldrich syndrome. Human organ and tissue transplants, including courses of treatment involving high-dose chemotherapy or radiotherapy and autologous bone marrow transplantation, stem cell rescue, or other hematopoietic support procedures for acute leukemia in remission, resistant non-Hodgkin's lymphoma, Hodgkin's disease, neuroblastoma, Ewing's sarcoma, multiple myeloma (after induction therapy), and non-inflammatory stage II breast cancer with 10 or more positive nodes and negative bone marrow but only when the individual qualifies as a candidate for the procedure under the health and age standards generally accepted by the national medical professional community. Eligible expenses for the donor will also be covered by the DSGHP.

Other courses of treatment involving high-dose chemotherapy or radiotherapy and autologous bone marrow transplantation, stem cell rescue, or other hematopoietic support procedures are not covered as organ and tissue transplants.

6. *Outpatient surgery.*
7. Podiatric surgery.
8. Reconstructive surgery. Benefits are available for Medically Necessary reconstructive surgery only if at least one of the following criteria is met. Reconstructive surgery or services must be:
 1. Made necessary by accidental injury; or
 2. Necessary for reconstruction or restoration of a functional part of the body following a covered surgical procedure for disease or injury; or
 3. Medically Necessary to restore or improve a bodily function, or
 4. Necessary to correct birth defects for covered dependent children who have functional physical deficits due to the birth defect.

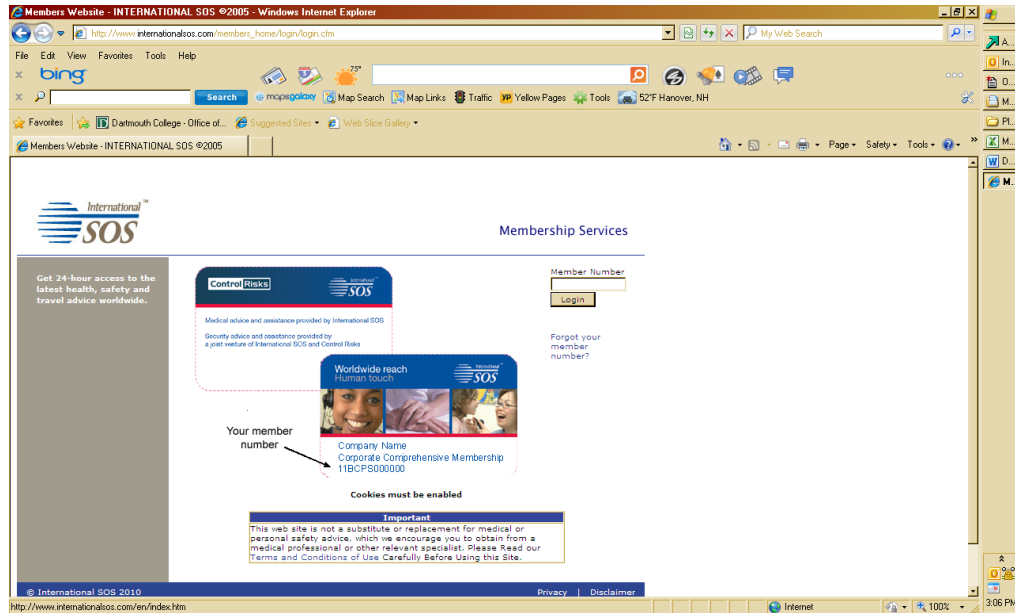
Reconstructive surgery or procedures or services that do not meet at least one of the above criteria is not covered.

Provided that the above definition of reconstructive surgery is met, the following reconstructive surgeries are eligible for Benefits:

1. Mastectomy for Gynecomastia
 2. Mandibular/Maxillary orthognathic surgery
 3. Port wine stain removal
9. Surgeon's expenses for the performance of a surgical procedure.
10. Surgery for conditions caused by obesity. Benefits are available for bariatric surgery that is medically necessary for the treatment of diseases and ailments caused by or resulting from obesity or morbid obesity. Surgery to treat the condition of obesity itself or morbid obesity itself is not covered. Except as stated in this provision no benefits are available for bariatric or any other surgery intended to manage or control appetite or body weight.
11. Surgical treatment of temporomandibular joint dysfunction (TMJ).
12. Two or more surgical procedures performed during the same session through the same or different incisions, natural body orifice, or operative field. The amount eligible for consideration is the sum of *usual and customary charges* for each procedure performed.

Travel Outside of the United States

As an added benefit the College provides a comprehensive program that provides emergency medical assistance with International SOS (ISOS). Services range from telephone advice, medical referrals, legal aide, to full-scale evacuation by private air ambulance. The ISOS network of 5,000 employees, including multilingual critical care and aero-medical specialists, operate 24 hours a day, 365 days a year from over 26 ISOS Alarm Call-In Centers around the world. Contact information may be found at: <http://www.internationalsos.com> & <http://www.dartmouth.edu/~rmi/rmstravel/>



Traveling? Need Certified Proof Of Coverage?

Contact the DSGHP Office via phone at (603) 646-9438, e-mail to Dartmouth.Student.Health.Plan@Dartmouth.edu or stop by the DSGHP Offices located in the 37 Dewey Field Road building to request a proof of coverage letter.

EXCLUDED EXPENSES/SERVICES

The DSGHP will not provide medical benefits for any expense which is not listed as a covered service or supply in this *Plan Document*, or any of the items listed below, regardless of *medical necessity* or recommendations of a *health care provider*.

1. A *residential treatment facility*, except as specifically approved by Dartmouth College Health Services.
2. Adoption expenses.
3. Any condition or disability sustained as a result of being engaged in an activity primarily for wage, profit, or gain, and that could entitle the *covered person* to a benefit under the Worker's Compensation Act or similar legislation.
4. Any condition, disability or expense sustained as a result of being engaged in: an illegal occupation; commission or attempted commission of an assault or other illegal act; intentional or *accidental* atomic explosion or other release of nuclear energy, whether in peacetime or wartime; participation in a civil revolution or a riot or a war; or act of war which is declared or undeclared.
5. Any refractive eye *surgery* or procedure designed to improve nearsightedness, farsightedness, and/or astigmatism by changing the shape of the cornea, including, but not limited to, LASIK, radial keratotomy and keratomileusis *surgery*.
6. Any treatment that is not a Covered Sickness or Injury or any service or supply that is not specifically listed in the *Covered Expenses/Services* section of this *Plan Document*.
7. Biofeedback.
8. Claims originally submitted more than one year after the date on which the service or supply was incurred.
9. *Custodial Care*.
10. Treatment for the correction of infertility (surgical or non-surgical).
11. Educational, vocational, or training services and supplies, except as specifically provided by Dartmouth College Health Services. This exclusion does not apply to treatment of diabetes and Smoking Cession.
12. Expenses exceeding the *usual and customary* charge for the geographic area in which services are rendered.
13. Expenses for broken appointments or telephone calls.
14. Expenses for preparing medical reports, itemized bills, or claim forms.
15. Expenses for prescription drugs or medicines. (See next section for Prescription Drug coverage.)
16. Expenses for services and supplies in excess of DSGHP limits or Benefit Maximums.
17. Expenses for supplies that do not require a *Physician's* prescription.
18. Expenses incurred for non-surgical treatment of the feet, including treatment of corns, calluses, and toenails, or other routine foot care, except as specified in *Covered Expenses/Services*.
19. Expenses incurred for services rendered prior to the effective date of coverage under the DSGHP or after coverage terminates, even though *illness* or *injury* started while coverage was in force.
20. Expenses used to satisfy plan *deductibles* or *coinsurance* amounts.
21. *Experimental/investigational* equipment, services, or supplies.
22. Eye examinations for diagnosis or treatment of a refractive error, including the fitting of eyeglasses or lenses, orthoptics, vision therapy, or supplies, except as specifically provided under Preventive Care Services.
23. Genetic counseling, except as specifically provided under Preventive Care Services.
24. Genetic testing, except as specifically provided under Preventive Care Services.
25. Unless specifically approved by the Dartmouth College Health Service, hearing aids or related supplies

26. Hypnosis.
27. Mailing and/or shipping and handling expenses.
28. Massage therapy or rolfing.
29. Orthognathic surgery.
30. Penile prosthetic implants.
31. Personal comfort or service items while confined in a *hospital*, such as, but not limited to, radio, television, telephone, and guest meals.
32. Reproductive sterilization, except as specifically provided under Preventive Care Services
33. Reversal of any reproductive sterilization procedure.
34. Routine PAP tests, routine physical exams, vaccinations, inoculations, or immunizations, except as specified in *Covered Expenses/Services* or Preventive Care Services.
35. Sales tax.
36. Services for or related to reconstructive surgery or cosmetic health services, except as specified in the Schedule of Benefits.
37. Services or supplies for which there is no legal obligation to pay for expenses, or charges which would not be made except for the availability of benefits under the DSGHP. This includes any expense incurred by an international student or dependent that would also be covered by another insurance plan, program, or system of socialized medicine in the absence of DSGHP coverage
38. Services or supplies for which there is no legal obligation to pay for such expenses, except for the availability of benefits under the DSGHP.
39. Services, supplies or benefits as required by reason of past or present service of any DSGHP-covered person's services in the armed forces of any government.
40. Services or supplies that are primarily and customarily used for a non-medical purpose, or used for environmental control or enhancement (whether or not prescribed by a physician), including but not limited to: equipment such as air conditioners, air purifiers, dehumidifiers, heating pads, hot water bottles, water beds, swimming pools, hot tubs, and any other clothing or equipment which could be used in the absence of an *illness or injury*.
41. Services related to Dental or *oral surgery*, except as specified in the Schedule of Benefits or accept as specifically provided under Preventive Care Services. (The plan covers surgical removal (extraction) of erupted teeth before radiation therapy for malignant disease.)
42. Services, supplies, or treatments which are not *medically necessary*.
43. Sex change *surgery*, except as specifically provided under *Covered Expenses/Services*. In the *Covered Expenses/Services*
44. Sex counseling.
45. Surgical impregnation procedures.
46. Bariatric surgery, unless medically necessary, for the treatment of diseases and ailments caused by or resulting from obesity or morbid obesity.
47. Surrogate expenses.
48. Travel expenses of a *covered person* other than local ambulance services to nearest medical facility equipped to treat the *illness or injury*, expect as specified in the Schedule of Benefits.
49. Travel expenses of a *physician*.
50. Treatment not prescribed or recommended by a *health care provider*.
51. Titers for routine testing (e.g., Hep. B, Varicella, etc.), except as specifically provided under Preventative Care Services.

PRESCRIPTION DRUG BENEFITS

General Requirements

Prescription Drug benefits are payable in connection with covered prescriptions and refills dispensed by licensed pharmacists. Although a *physician's* prescription is required, fulfilling this requirement does not guarantee that a particular drug will be covered.

The DSGHP utilizes EXPRESS SCRIPTS for the administration of its Prescription Drug Benefits. EXPRESS SCRIPTS has a nation-wide network of participating pharmacies. The Dartmouth Health Services Pharmacy is a member of the EXPRESS SCRIPTS Pharmacy network.

When you fill a covered prescription at a Network Pharmacy and show your Plan Identification card with the EXPRESS SCRIPTS logo, the Pharmacy will submit the claim on your behalf and accept the *network maximum allowable cost* as full payment. You will pay only your share of the expense, which may include the Prescription *plan year deductible*, your *coinsurance*, or a combination of the two.

When you fill a covered prescription at a Pharmacy outside the Network, you must pay for the full cost of the purchase and then submit a claim for benefits to EXPRESS SCRIPTS for reimbursement.

Non-EXPRESS SCRIPTS Network Pharmacies may charge you more than the *network maximum allowable cost*. Charges in excess of the *network maximum allowable cost* are not covered by the DSGHP.

Covered Drugs

When all of the provisions of the DSGHP are satisfied, the DSGHP will provide benefits as specified in the Schedule of Benefits for the following *medically necessary* covered drugs, devices, and supplies,

1. Anti-malarial drugs, for preventive or therapeutic purposes.
2. Compounded Medications of which at least one ingredient is a *legend* drug.
3. Federal *Legend Drugs* and State Restricted Drugs.
4. Hemophillia Factors up to a plan maximum of 5 treatments per plan year*
*Additional treatments may be approved through pre-authorization of DSGHP's Case Management Services. 844-206-0372
5. Insulin (including insulin needles and diabetic supplies).
6. *Legend* Smoking Deterrents.
7. *Legend* Vitamin B12 (all dosage forms).
8. Necessary prescription medications and vaccines when required for international travel and approved by Dartmouth College Health Services.
9. Oral fluoride products.
10. Oral, transdermal, intravaginal contraceptives, and contraceptive injections, except as specifically provided under Preventative Care Services.
11. Plan B emergency contraceptive medications, except as specifically provided under Preventative Care Services.
12. Prenatal vitamins.
13. Enteral Formula and modified low protein food products.

Dispensing Limits

The amount of drug which may be dispensed per prescription or refill (regardless of dosage form) is limited to a 90 day supply. Other dispensing limits may be imposed as required by federal or state regulation or for other reasons.

Excluded Drugs

Some items excluded under Prescription Drug Benefits may be eligible for coverage as a Medical Benefit. Expenses for the following are not covered by the DSGHP unless specifically listed as a benefit under "Covered Drugs":

1. Allergy sera (covered under Medical Benefits).
2. Any prescription refilled in excess of the number of refills specified by the ordering physician, or any refill dispensed one year after the original order.
3. Biologicals and blood or blood plasma. Immunization agents or vaccines except as specifically provided by Dartmouth College Health Services.
4. Charges for the administration or injection of any drug.
5. Cosmetic drugs and drugs used to promote or stimulate hair growth.
6. Drugs labeled "Caution-Limited by Federal law to investigational use," or "experimental drugs," even though a charge is made to the individual.
7. Drugs not classified as Federal *Legend Drugs* (i.e., over-the-counter drugs and products).
8. Fertility and impotency drugs.
9. *Legend* vitamins.
10. Medication dispensed in excess of the dispensing limits.
11. Medication for which the cost is recoverable under any workers' compensation or occupational disease law or any state or governmental agency, or medication furnished by any other drug or medical service for which no charge is made to the insured.
12. Medication which is to be taken by or administered to an individual, in whole or in part, while he or she is a patient in a licensed facility.
13. Non-systemic contraceptives, devices or implants except as specifically provided by the Major Medical.
14. Services or products that are determined by the DSGHP as not *medically necessary*.



2013 Big Green Bus
Photo By: Eli Burakian '00

DENTAL SAVINGS PROGRAM

As part of your membership in the DSGHP, you automatically have access to the Basix Dental Savings Program. The Basix program is a network of dentists who have agreed to accept rates lower than their billed charges when payment is made at the time of service. It is important to understand this program is not insurance, there are no covered benefits through the Basix program. For more Basix information please go to this website: http://www.dartmouth.edu/~health/resources/dental/basix_dental.html.

In addition please note that DSGHP is a major medical policy. It provides no dental benefits except for dental expenses due to accidental injury to teeth, excluding biting or chewing injuries.

Basix Dental Savings Program

The cost of dental care is a major concern to well, nearly everyone! To help, the Dartmouth Student Group Health Plan (DSGHP) has incorporated the Basix Dental Savings Program into the plan beginning with the 2013-2014 plan year. Basix contracts with dentists who agree to charge a reduced fee to people enrolled in the DSGHP. You must pay the dentist at the time of service to receive the negotiated rate. It is important to understand the Dental Savings Program is not dental insurance.

Savings vary depending upon the type of service received and the contracted dentist providing the service, but can be as high as 50%. To use the program simply:

1. Make an appointment with a contracted dentist; all the contracted dentists are listed on the Basix website, www.basixstudent.com.
2. Make sure the dental office understands that you have access to the Basix program. Separate Basix identification cards are not issued; just show the dental office your DSGHP identification card. The dental office can also call the DSGHP Office at 603-646-9438 to confirm enrollment.
3. The fee schedule heading for each dentist has a link which opens a page that has all of the information both you and the dentist will need to make your visit go smoothly.
4. Remember, you must pay for the services you receive at the time of service, so make sure you understand what forms of payment the dentist accepts. The Basix program makes no payment to providers.

Full details of the program can be viewed at: www.basixstudent.com. Once at the home page, select the link for Dartmouth College. You may also contact Basix via phone at 888-274-9961 or via e-mail through the Basix website.

Pediatric Dental Benefits

Class	Deductible	Coinsurance	Services
A: Basic	\$0	100%	Diagnostic and Preventive
B: Intermediate	\$75	80%	Minor Restorative, Endodontic, Periodontic, Prosthodontic, Oral Surgery
C: Major	\$75	75%	Major Restorative, Endodontic, Periodontic, Prosthodontic
D: Orthodontics	\$75	50%	Orthodontic; medically necessary

Plan Allowance: The plan provides payment based on Usual & Customary Charges.

General Exclusions

The exclusions in this section apply to all benefits. Although we may list a specific service as a benefit, we will not cover it unless we determine it is necessary for the prevention, diagnosis, care, or treatment of a covered condition. We do not cover the following:

- Services and treatment not prescribed by or under the direct supervision of a dentist, except in those states where dental hygienists are permitted to practice without supervision by a dentist. In these states, we will pay for eligible covered services provided by an authorized dental hygienist performing within the scope of his or her license and applicable state law;
- Services and treatment which are experimental or investigational;
- Services and treatment which are for any illness or bodily injury which occurs in the course of employment if a benefit or compensation is available, in whole or in part, under the provision of any law or regulation or any government unit. This exclusion applies whether or not you claim the benefits or compensation;
- Services and treatment performed prior to your effective date of coverage;
- Services and treatment incurred after the termination date of your coverage unless otherwise indicated;
- Services and treatment which are not dentally necessary or which do not meet generally accepted standards of dental practice.
- Services and treatment resulting from your failure to comply with professionally prescribed treatment;
- Telephone consultations;
- Any charges for failure to keep a scheduled appointment;
- Any services that are considered strictly cosmetic in nature including, but not limited to, charges for personalization or characterization of prosthetic appliances;
- Services related to the diagnosis and treatment of Temporomandibular Joint Dysfunction (TMD);
- Charges for copies of your records, charts or x-rays, or any costs associated with forwarding/mailling copies of your records, charts or x-rays;
- Those submitted by a dentist, which is for the same services performed on the same date for the same member by another dentist;
- Those provided free of charge by any governmental unit, except where this exclusion is prohibited by law;
- Those for which the member would have no obligation to pay in the absence of this or any similar coverage;
- Those which are for specialized procedures and techniques;
- Those performed by a dentist who is compensated by a facility for similar covered services performed for members;
- Duplicate, provisional and temporary devices, appliances, and services;
- Plaque control programs, oral hygiene instruction, and dietary instructions;
- Services to alter vertical dimension and/or restore or maintain the occlusion. Such procedures include, but are not limited to, equilibration, periodontal splinting, full mouth rehabilitation, and restoration for misalignment of teeth;
- Treatment or services for injuries resulting from the maintenance or use of a motor vehicle if such treatment or service is paid or payable under a plan or policy of motor vehicle insurance, including a certified self-insurance plan;
- Treatment of services for injuries resulting from war or act of war, whether declared or undeclared, or from police or military service for any country or organization;
- Hospital costs or any additional fees that the dentist or hospital charges for treatment at the hospital (inpatient or outpatient);
- Use of material or home health aides to prevent decay, such as toothpaste, fluoride gels, dental floss and teeth whiteners;
- Cone Beam Imaging and Cone Beam MRI procedures;
- Sealants for teeth other than permanent molars;
- Precision attachments, personalization, precious metal bases and other specialized techniques;
- Orthodontic services provided to a dependent of an enrolled member who has not met the 12 month waiting period requirement;
- Repair of damaged orthodontic appliances;
- Replacement of lost or missing appliances;
- Fabrication of athletic mouth guard;
- Internal and external bleaching;
- Nitrous oxide;
- Oral sedation;

- Topical medicament center;
- Orthodontic care for a member or spouse;
- Bone grafts when done in connection with extractions, apicoectomies or non-covered/non eligible implants;

Pediatric Vision Benefits

Key benefit features	High option
Routine eye exam	\$0 copay
Frames (once every calendar year)	\$150 allowance
Lenses— single, bifocal, trifocal, lenticular (once every calendar year in lieu of contacts)	\$10 copay
Polycarbonate lenses; scratch coating; UV treatment; tint, fashion and gradient tinting, oversized glass-grey #3 prescription sunglass lenses, and low vision items	\$0 copay
Contacts (once every calendar year in lieu of lenses)	\$150 allowance
Standard progressive lenses	\$50 copay
Most premium progressive lenses	\$70—\$95 copay

COORDINATION OF BENEFITS

When you and/or your dependents are covered under more than one medical plan, one plan is considered primary and the other secondary. The primary plan always pays first and usually pays full regular benefits while the secondary plan may pay a portion of the claim not paid by the other plan. This process is known as coordination of benefits.

Except as specifically provided below, the DSGHP will always be secondary in coordinating coverage with other health insurance plans. For example, when a student is covered by the DSGHP and a parent's health insurance coverage, the parent's insurance must pay its full benefits on a primary basis before the DSGHP will provide coverage.

This always secondary provision for coordination of benefits does not apply to benefits payable under the DGSHP for outpatient mental health care services or for any care or related treatment when a covered individual is a victim of sexual assault. Primary payor status for the DSGHP for mental health care services only applies to charges billed by a mental health care professional. Primary payor status does not apply to health care facility charges.

As secondary coverage, the DSGHP will reimburse eligible medical expenses that were not paid by the primary plan, subject to the following limitations: (1) the DSGHP will pay no more than it would have paid if it had been the primary insurer, and (2) the amount that the DSGHP pays, combined with the amount paid by the other, primary plan, will not exceed the total amount of eligible medical expenses incurred. For purposes of coordination of benefits, eligible medical expenses mean any *usual and customary charges* covered in part or full by the DSGHP.

The DSGHP will always be secondary in coordinating benefits with other plans except for the following circumstances for dependent coverage:

- When it covers the dependent child of the natural parent designated by court order to be responsible for the child's health care expenses.
- In the absence of a court order specifying otherwise, it covers the dependent child of the natural parent having legal custody of the child.
- In the absence of a court order specifying otherwise, it covers the dependent child of a stepparent who is the spouse of the natural parent having legal custody of the child.

Other Group Plans

Any group health plan that does not contain a coordination of benefits provision will be considered primary.

Right to Make Payments to Other Organizations

Whenever payments which should have been made by the DSGHP have been made by any other plans(s), the DSGHP has the right to pay the other plan(s) any amount necessary to satisfy the terms of this coordination of benefits provision. Amounts paid will be considered benefits paid under the DSGHP and, to the extent of such payments, the DSGHP will be fully released from any liability regarding the person for whom payment was made.

OTHER IMPORTANT PLAN PROVISIONS

Assignment of Benefits

Generally, benefits are payable to you and can only be paid directly to another party upon signed authorization from you.

All benefits payable by the DSGHP may be assigned to the Provider of services or supplies at your option. Payments made in accordance with an assignment are made in good faith and release the DSGHP's obligation to the extent of the payments. Payments will also be made in accordance with any assignment of rights required by a state *Medicaid* plan.

Alternate Payees

If conditions exist under which a valid release or assignment cannot be obtained, the DSGHP may make payment to any individual or organization that has assumed the care or principal support for you and is equitably entitled to payment. The DSGHP must make payments to your separated/divorced spouse, state child support agencies or *Medicaid* agencies if required by a QMCSO or state *Medicaid* law.

The DSGHP may also honor benefit assignments made prior to your death in relation to remaining benefits payable by the DSGHP.

Any payment made by the DSGHP in accordance with this provision will fully release the DSGHP of its liability to you.

Necessary Information

When you request benefits, you must furnish all the information required to implement plan provisions. Your signature on the claim form permits the DSGHP to release or obtain such information without your further authorization. The DSGHP may, without further authorization or notice to any person, release to or obtain from any organization or person, information needed to implement plan provisions. The DSGHP's privacy practices are described in the Health Service Notice on Privacy Practices.

Regulation of the DSGHP

The DSGHP is not an employer-sponsored health plan. Accordingly, the rules and regulations of the Employee Retirement Income Security Act of 1974 (ERISA) the Consolidated Omnibus Budget Reconciliation Act of 1996 (COBRA), and other federal laws that apply exclusively to employer-sponsored health plans are not applicable to the DSGHP. Similarly, as a partially self-funded health plan, the DSGHP is not regulated by the State of New Hampshire's Department of Insurance.

As of the date of publication of this *Plan Document*, the federal laws and regulations that are applicable to the DSGHP include but are not limited to:

- Title IX of the Education Amendments of 1972. The DSGHP provides pregnancy benefits on the same basis as any other temporary disability pursuant to the requirements of Title IX of the Education Amendments of 1972.
- Section 504 of the Rehabilitation Act of 1973.
- Age Discrimination Act of 1975.
- Health Insurance Portability and Accountability Act of 1996 (refer to the Privacy Notice at Dartmouth College Health Services).

- Regulations of the United States Information Agency that are applicable to VISA recipients.

SUBROGATION, REIMBURSEMENT, AND RECOVERY

Subrogation Rights

“Subrogation” refers to the right of the DSGHP to be substituted in place of any covered individual with respect to that covered individual’s legal right of action against the person who may have wrongfully caused the *illness or injury* that resulted in the payment of benefits by the DSGHP. The DSGHP’s subrogation provisions apply when another party (including an insurance carrier) is or may be liable for a covered individual’s *illness or injury* and the DSGHP has already paid benefits for treatment of that *illness or injury*.

The DSGHP may, at its discretion, start any legal action or administrative proceeding it deems necessary to protect its right to recover any amount it has paid as plan benefits, and it may try to settle any such action or proceeding in the name of and with the full cooperation of the covered individual. In doing so, however, the DSGHP will not represent or provide legal representation for any covered individual with respect to that covered individual’s damages to the extent those damages exceed the amount of plan benefits.

In addition, the DSGHP may, at its discretion, intervene in any claim, legal action, or administrative proceeding started by any covered individual against any person or that person’s insurer on account of any alleged negligent, intentional, or otherwise wrongful action that may have caused or contributed to the covered individual’s *injury or illness* that resulted in the payment of benefits by the DSGHP.

The DSGHP’s legal costs in subrogation matters will be borne by the DSGHP. The legal costs of covered individuals will be borne by such covered individuals.

Reimbursement Rights

The DSGHP’s reimbursement provisions apply when you or the individuals you cover under the DSGHP (i.e., covered individuals) receive any payment by settlement, verdict or otherwise, including from an insurance policy, for an *illness or injury* caused by a third party. These payments are referred to as a recovery.

If you or another covered individual have received a recovery, the DSGHP will subtract the amount of the recovery from the benefits it would otherwise pay for treatment of that *illness or injury*. If the DSGHP has already paid benefits for treatment of the *illness or injury*, you or the covered individual must promptly reimburse the DSGHP from any recovery received for the amount of benefits paid by the DSGHP.

Reimbursement must be made regardless of whether the covered individual is fully compensated (i.e., made whole) by the recovery and regardless of how the payment is characterized. Unless agreed to in writing by the DSGHP *Administrator*, the reimbursement may not be reduced for any legal or other expenses incurred in connection with the recovery against the third party or that third party’s insurer. By accepting benefits from the DSGHP, all covered individuals are deemed to agree to this repayment provision.

Covered individuals may be required to execute an agreement under which they jointly and severally accept the following:

- Grant the DSGHP a first priority lien against the proceeds of any recovery received.
- Assign to the DSGHP any benefit they may have under any insurance policy or other coverage.
- Agree to hold the proceeds of any recovery received in trust for the DSGHP.
- Cooperate with the DSGHP and its agents in order to protect the DSGHP’s reimbursement rights.
- Payments of benefits under the DSGHP may be conditioned on execution of such an agreement.

The DSGHP is only responsible for those legal costs to which it agrees in writing and will not otherwise bear the legal costs of covered individuals.

If any covered individual fails to reimburse the DSGHP as required by this section, the DSGHP may apply any future plan benefits that may become payable on behalf of all covered individuals to the amount not reimbursed or it may enforce its rights through other legal or equitable means.

Right of Recovery

Whenever payments have been made in excess of the amount necessary to satisfy the provisions of the DSGHP, the DSGHP has the right to recover these excess payments from any individual (including yourself), insurance company, or other organization to whom the excess payments were made or to withhold payment, if necessary, on future benefits until the overpayment is recovered.

If excess payments were made for services rendered to your dependent(s), the DSGHP has the right to withhold payment on your benefits until the overpayment is recovered.

Further, whenever payments have been made based on fraudulent information provided by you, the DSGHP will exercise its right to withhold payment on future benefits until the over-payment is recovered.

CLAIM PROCEDURES

How to File a Claim for Medical Benefits

Medical claim forms may be obtained from the DSGHP Office at the Dartmouth College Health Service or downloaded from a link at dartgo.org/studentinsurance.

A separate claim form must be filed for each *illness, injury or condition* for each person for which health care expenses are incurred. Be sure to:

- Complete the Student's portion of the claim form in full. Answer all questions. State "none" or "N/A" when the question does not apply.
- For *outpatient* expenses incurred in the *Hanover NH Area*, you must state whether you were referred to the service by a Dartmouth athletic trainer or a *practitioner* at the Dartmouth College Health Service.
- Attach all necessary documentation of expenses to the claim form. Documentation must include:
 - The Patient's name and date(s) of service.
 - The Provider's name, address, phone number, degree, federal tax identification number and *National Provider Identifier number. (NPI)*
 - The diagnosis. (i.e., the nature of the *Illness, Injury* or condition)
 - A description of services or supplies provided, detailing the charge for each service or supply.
- If another plan is the primary payor, attach a copy of the other plan's *Explanation of Benefits* (EOB). Mail completed claim forms with supporting documents to:

Cigna PPO
PO Box 188061
Chattanooga, TN 37422-8061

www.healthsmart.com (claim forms are also available at this web site)

Within the United States, if you have any questions regarding a claim, please call HealthSmart at 844-206-0372, Monday through Friday, 8:00 a.m. to 5:00 p.m., Eastern Time. Outside the U.S., call 330-576-9000.

All claims for medical benefits must be filed with the DSGHP within a 12-month period from the date the expense is incurred.

How to File a Claim for Prescription Drug Benefits

The Dartmouth Health Service Pharmacy and other EXPRESS SCRIPTS Pharmacies will submit your claim for you if you show your DSGHP ID card at the time of purchase. You are responsible for submitting your claim yourself when you fill prescriptions at Non-network Pharmacies.

To submit your own claim for a prescription drug expense, send the original receipt and a completed EXPRESS SCRIPTS prescription drug claim form to:

EXPRESS SCRIPTS
PO Box 2872
Clinton, IA 52733-2872

EXPRESS SCRIPTS prescription drug claim forms can be downloaded at www.healthsmart.com

Questions concerning EXPRESS SCRIPTS coverage can be directed to HealthSmart at 844-206-0372 or at Express Scripts Member services 800-711-0917.

All claims for prescription drugs must be filed with the DSGHP within a 12-month period from the date the expense is incurred.

How to Appeal a Denial of Benefits

Claim Decisions on Claims and Eligibility

Information regarding *urgent care claims* is provided to a Covered Person under the disclosure requirements of applicable law; the Plan does not make treatment decisions. Any decision to receive treatment must be made between the patient and his or her healthcare provider; however, the Plan will only pay benefits according to the terms, conditions, limitations and exclusions of this Plan.

There are no Urgent Care requirements under this Plan and therefore, there are no rights to appeal a pre-service Urgent Care claim denial.

Appealing a Denial of a Pre-Service Claim

If a claim is denied in whole or in part, the Covered Person will receive written notification of the Adverse Benefit Determination. A claim denial will be provided by the Plan showing:

1. The reason the claim was denied;
2. Reference(s) to the specific plan provision(s) or rule(s) upon which the decision was based which resulted in the Adverse Benefit Determination;
3. Any additional information needed to perfect the claim and why such information is needed; and
4. An explanation of the Covered Person's right to appeal the Adverse Benefit Determination for a full and fair review and the right to bring a civil action following an Adverse Benefit Determination on appeal.

If a Covered Person does not understand the reason for any Adverse Benefit Determination, he or she should contact the Plan at the address or telephone number shown on the claim denial.

The Covered Person must appeal the Adverse Benefit Determination before the Covered Person may exercise his or her right to bring a civil action. This Plan provides two (2) levels of benefit determination review and the Covered Person must exercise both levels of review before bringing a civil action.

To initiate the first level of benefit review, the Covered Person must submit in writing an appeal or a request for review of the Adverse Benefit Determination to the Plan within one hundred eighty (180) days after the Adverse Benefit Determination. The Covered Person should include any additional information supporting the appeal, or supply the information required by the Plan that was not initially provided, and submit the appeal to the Plan within the 180-day time period. Failure to appeal the Adverse Benefit Determination within the 180-day time period will render the determination final. Any appeal received after the 180-day time period has expired will receive no further consideration.

Appeals or requests for review of Adverse Benefit Determinations must be submitted to the Plan in writing, and supporting materials may be submitted via mail, electronic claims submission process, facsimile (fax) or electronic mail (e-mail).

First Level of Benefit Determination Review

The first level of benefit determination review is done by the Claims Administrator. The Claims Administrator will research the information initially received and determine if the initial determination was appropriate based on the terms and conditions of the Plan and other relevant information. Notice of the decision on the first level of review will be sent to the Covered Person within fifteen (15) days following the date the Claims Administrator receives the request for reconsideration.

If, based on the Claims Administrator's review, the initial Adverse Benefit Determination remains the same and the Covered Person does not agree with that benefit determination, the Covered Person must initiate the second level of benefit review. The Covered Person must request the second review in writing and send it to the Claims Administrator, not later than sixty (60) days after receipt of the Claims Administrator's decision from the first level of review. Failure to initiate the second level of benefit review within the 60-day time period will render the determination final.

Second Level of Benefit Determination Review

The Plan will review the claim in question along with the additional information submitted by the Covered Person. The Plan will conduct a full and fair review of the claim by a person(s) who are neither the original decision maker nor the decision maker's subordinate. The Plan cannot give deference to the initial benefit determination. The Plan may, when appropriate or if required by law, consult with relevant health care professionals in making decisions about appeals that involve specialized medical judgment. Where the appeal involves issues of medical necessity or experimental treatment, the Plan will consult with a health care professional with appropriate training who was neither the medical professional consulted in the initial determination or his or her subordinate.

After a full and fair review of the Covered Person's appeal, the Plan will provide a written or electronic notice of the final benefit determination, which contains the same information as notices for the initial determination, within fifteen (15) days.

Appealing a Denial of a Post-Service Claim

If a claim is denied in whole or in part, the Covered Person will receive written notification of the Adverse Benefit Determination. A claim Explanation of Benefits (EOB) will be provided by the Plan showing:

The reason the claim was denied;

1. Reference(s) to the specific plan provision(s) or rule(s) upon which the decision was based which resulted in the Adverse Benefit Determination;
2. Any additional information needed to perfect the claim and why such information is needed; and
3. An explanation of the Covered Person's right to appeal the Adverse Benefit Determination for a full and fair review and the right to bring a civil action following an Adverse Benefit Determination on appeal.

If a Covered Person does not understand the reason for any Adverse Benefit Determination, he or she should contact the Claims Administrator at the address or telephone number shown on the EOB form.

The Covered Person must appeal the Adverse Benefit Determination before the Covered Person may exercise his or her right to bring a civil action. This Plan provides two (2) levels of benefit determination review and the Covered Person must exercise both levels of review before bringing a civil action.

To initiate the first level of benefit review, the Covered Person must submit in writing an appeal or a request for review of the Adverse Benefit Determination to the Plan within one hundred eighty (180) days after the Adverse Benefit Determination. The Covered Person should include any additional information supporting the appeal, or supply the information required by the Plan that was not initially provided, and submit the appeal to the Plan within the 180-day time period. Failure to appeal the Adverse Benefit Determination within the 180-day time period will render the determination final. Any appeal received after the 180-day time period has expired will receive no further consideration.

Appeals or requests for review of Adverse Benefit Determinations must be submitted to the Plan in writing, and supporting materials may be submitted via mail, electronic claims submission process, facsimile (fax) or electronic mail (e-mail).

First Level of Benefit Determination Review

The first level of benefit determination review is done by the Claims Administrator. The Claims Administrator will research the information initially received and determine if the initial determination was appropriate based on the terms and conditions of the Plan and other relevant information. Notice of the decision on the first level of review will be sent to the Covered Person within thirty (30) days following the date the Claims Administrator receives the request for reconsideration.

If, based on the Claims Administrator's review, the initial Adverse Benefit Determination remains the same and the Covered Person does not agree with that benefit determination, the Covered Person must initiate the second level of benefit review. The Covered Person must request the second review in writing and send it to the Claims Administrator, not later than sixty (60) days after receipt of the Claims Administrator's decision from the first level of review. Failure to initiate the second level of benefit review within the 60-day time period will render the determination final.

Second Level of Benefit Determination Review

The Plan will review the claim in question along with the additional information submitted by the Covered Person. The Plan will conduct a full and fair review of the claim by a person(s) who is neither the original decision maker nor the decision maker's subordinate. The Plan cannot give deference to the initial benefit determination. The Plan may, when appropriate or if required by law, consult with relevant health care professionals in making decisions about appeals that involve specialized medical judgment. Where the appeal involves issues of medical necessity or

experimental treatment, the Plan will consult with a health care professional with appropriate training who was neither the medical professional consulted in the initial determination or his or her subordinate.

After a full and fair review of the Covered Person's appeal, the Plan will provide a written or electronic notice of the final benefit determination within a reasonable time, but no later than thirty (30) days from the date the appeal is received by the Plan.

All claim payments are based upon the terms contained in the Plan Document, on file with the Plan Administrator and the Claims Administrator. The Covered Person may request, free of charge, more detailed information, names of any medical professionals consulted and copies of relevant documents, as defined in and required by law, which were used by the Plan to adjudicate the claim.

Independent External Review

After exhaustion of all appeal rights stated above, a Covered Person may also request a final independent external review of any Adverse Benefit Determination involving a question of Medical Necessity, or other issue requiring medical expertise for resolution.

To assert this right to independent external medical review, the Covered Person must request such review in writing within one hundred twenty (120) days after a decision is made upon the second level benefit determination above.

If an independent external review is requested, the Claims Administrator will forward the entire record on appeal, within ten (10) days, to an independent external review organization (IRO) selected randomly. The IRO will notify the Covered Person of its procedures to submit further information.

The IRO will issue a final decision within forty-five (45) days after receipt of all necessary information.

The decision of the IRO will be final and binding except that the Covered Person shall have an additional right to appeal the matter to a court with jurisdiction.

If your claim for a benefit was denied in whole or in part, you may appeal the decision through the following procedure:

- Within 60 days of receipt of the denial letter or explanation of benefits (EOB) form from HealthSmart, you may request, in writing or verbally, that the DSGHP conduct a review of the processed claim. The DSGHP will review the processed claim and inform you whether or not an error was made. Any errors will be corrected promptly.
- If you are not satisfied with the result of this review, you may request a second review. This request must be in writing and must be submitted to the DSGHP within 60 days of the date of the completion of the first review. The request should state in clear and concise terms why you disagree with the way the claim was processed.
- In most cases, the decision on the second review will be furnished in writing within 60 days but in no case more than 120 days.

All requests for a review of denied benefits should include a copy of the initial denial letter and any other pertinent information. Send all information to:

**HealthSmart
3320 West Market Street Suite 100
Fairlawn, Ohio 44333**

Except in extraordinary circumstances, requests for appeal which do not comply with this procedure will not be considered.

DEFINITIONS

The following terms define specific wording used in the DSGHP. These definitions should not be interpreted to extend coverage unless specifically provided for under the provisions of the DSGHP.

Accident (al): An unforeseen and unavoidable event resulting in an *injury*.

Adverse benefit determination: This means that for some reason, the health plan has decided that it's not going to pay a claim, or it's not going to pay the dollar amount that the consumer wanted. The denial can be for many reasons.

For example:

1. The health plan simply doesn't cover the procedure;
2. The consumer's employer tells the health plan that, at the time the consumer received the service, the consumer wasn't eligible to participate in the plan; or
3. The health plan defines the service as "experimental or investigational" or "not medically necessary."
4. When consumers receive adverse benefit determinations from their health plans, consumers can file an appeal, and this manual provides tips for filing appeals.

Ambulatory Surgical Facility: A public or private facility licensed and operated according to the law, which does not provide services or accommodations for a patient to stay overnight. The facility must have an organized medical staff of *physicians*, maintain permanent facilities equipped and operated primarily for the purpose of performing surgical procedures, and supply registered professional nursing services whenever a patient is in the facility.

Biologically Based Mental Health Care Conditions: Each insurer that issues or renews any policy of group or blanket accident or health insurance under RSA 415:18 and each nonprofit health service corporation under RSA 420-A and health maintenance organization under RSA 420-B providing benefits for disease or sickness in the State of New Hampshire shall provide benefits for treatment and diagnosis of certain mental illnesses as defined in most current Diagnostic and Statistical Manual (DSM):

1. Schizophrenia and other psychotic disorders
2. Schizoaffective disorder
3. Major depressive disorder
4. Bipolar disorder
5. Anorexia nervosa and bulimia nervosa
6. Obsessive-compulsive disorder
7. Panic disorder
8. Pervasive developmental disorder or autism
9. Chronic post-traumatic stress disorder

Coverage shall be under the same terms and conditions and which are no less extensive than coverage provided for any other type of health care for physical illness. The benefits required under this section begin when benefits provided under RSA 415:18-a, and RSA 420-B: 8-b, as applicable are exhausted.

Birthing Center: A public or private facility, other than private offices or clinics of *physicians*, which meets the free standing birthing center requirements of the State Department of Health in the state where the *covered person* receives the services.

1. The birthing center must provide: a facility which has been established, equipped, and operated for the purpose of providing prenatal care, delivery, immediate postpartum care and care of a child born at the center; supervision of at least one specialist in obstetrics and gynecology; a physician or certified nurse midwife at all births and immediate postpartum period; extended staff privileges to physicians who practice obstetrics and gynecology in an area hospital; at least two beds or two birthing rooms; full-time nursing services directed by an R.N. or certified nurse midwife; arrangements for diagnostic X-ray and lab services; and the capacity to administer local anesthetic or to perform minor surgery.
2. In addition, the facility must only accept patients with low risk pregnancies, have a written agreement with a hospital for emergency transfers, and maintain medical records on each patient and child.

Chemical/Substance Abuse Treatment Facility: A public or private facility, licensed and operated according to the law and accredited by the Joint Commission on the Accreditation of Hospitals, which provides a program for diagnosis, evaluation and effective treatment of chemical/substance abuse, detoxification services, and professional nursing care provided by licensed practical *nurses* who are directed by a full-time R.N. The facility must have a *physician* on staff or on call.

The facility must also prepare and maintain a written plan of treatment for each patient based on medical, psychological, and social needs.

Chiropractic Services: The detection and correction, by manual or mechanical means, of the interference with nerve transmissions and expressions resulting from distortion, misalignment, or dislocation of the spinal (vertebrae) column.

Co-insurance: Coinsurance is the portion of *Covered Expenses/Services* required to be paid by the DSGHP after satisfaction of any applicable *deductible* AND *co-payment*. This percentage applies only to *Covered Expenses/Services* which do not exceed *usual and customary charges*. The *covered person* is responsible for all non-*Covered Expenses/Services* and any amount which exceeds the *usual and customary charge* for *Covered Expenses/Services*.

Concurrent Care Review: For patients who face early termination or reduction of benefits for a course of treatment previously certified by the Plan, a decision by the Plan to reduce or terminate benefits for ongoing care is considered an Adverse Benefit Determination. (Note: Exhaustion of the Plan's benefit maximums is not an Adverse Benefit Determination.) The Plan will notify the Covered Person sufficiently in advance to allow an appeal for uninterrupted continuing care before the benefit is reduced or terminated. Any request to extend an Urgent Care course of treatment beyond the initially prescribed period of time must be decided within twenty-four (24) hours of the Plan's receipt of the request. The appeal for ongoing care or treatment must be made to the Plan at least twenty-four (24) hours prior to the expiration of the initially prescribed period.

Co-payment: The portion of a claim or medical expense that the *covered person* must pay out of his or her pocket to a *provider* or a facility for each service. A *co-payment* is usually a fixed amount that is paid at the time the service is rendered.

Cosmetic Surgery: A procedure performed primarily for psychological purposes or to preserve or improve appearance rather than to restore the anatomy and/or functions of the body which are lost or impaired due to an *illness* or *injury*.

Covered Expenses/Services: A health service or supply that is eligible for benefits when performed by a *practitioner* or *physician*. A *Covered Expense/Service* must be a medical expense or charge that is specifically identified in this *Plan Document* as being covered by the DSGHP and is not otherwise excluded by the DSGHP.

Covered Person(s): A student or dependent that is covered by the DSGHP.

Custodial Care: Services and supplies furnished primarily to assist an individual in the activities of daily living. Activities of daily living include such things as bathing, feeding, administration of oral medicines, or other services that can be provided by persons without the training of a *health care provider*.

DSGHP: The Dartmouth Student Group Health Plan provided by Dartmouth College and explained in this *Plan Document*.

DSGHP Administrator: Dartmouth College is the sole fiduciary of the DSGHP and exercises all discretionary authority and control over the administration of the DSGHP and the management and disposition of plan assets. The *DSGHP Administrator* shall have the sole discretionary authority to determine eligibility for plan benefits or to construe the terms of the DSGHP. The *DSGHP Administrator* has the right to amend, modify, or terminate the DSGHP in any manner, at any time, regardless of the health status of any plan participant or beneficiary.

The *DSGHP Administrator* has retained HealthSmart to perform claims processing and other specified services in relation to the DSGHP. HealthSmart is not a fiduciary of the DSGHP and will not exercise any of the discretionary authority and responsibility granted to the *DSGHP Administrator*, as described above.

Deductible (Plan Year Aggregate Deductible): The *plan year aggregate deductible* is the total amount of *Covered Expenses/Services* a *covered person* or family must pay during each *plan year* before the DSGHP will consider expenses for reimbursement. Expenses from separate *illnesses* or *injuries* may be used to satisfy the *deductible*.

Diagnostic Charges: The *usual and customary charges* for X-ray or laboratory examinations made or ordered by a *physician* or *practitioner* in order to detect a medical condition.

Domestic Partner: An individual who is of the same gender as the student and who satisfies the requirements for recognition as a *domestic partner* by Dartmouth College.

Durable Medical Equipment: Equipment able to withstand repeated use for the therapeutic treatment of an active *illness* or *injury*. Such equipment will not be covered under the DSGHP if it could be useful to a person in the absence of an *illness* or *injury* and could be purchased without a *physician's* prescription.

Explanation of Benefits (EOB): A form, a statement, or document sent to the subscriber by the insurance company explaining the action, such as what medical treatment or services were provided, amount to be billed, and payments made on each claim. EOB's are sent by the insurance company to both members and providers. It provides necessary information about claim payment information and patient responsibility amounts.

Experimental or Investigational Services: Including but not limited to transplants, which are educational in nature or any treatment (including pharmacological regimes) that are not recognized as generally accepted medical practice by the medical profession. Criteria for determining whether or not a procedure or treatment will be considered *experimental* or *investigational* will include, but not be limited to, the following:

1. Whether the service has final approval from the appropriate government regulatory bodies (FDA, or other regulatory authority as appropriate).
2. Whether the procedure or treatment is generally accepted by the medical profession.
3. Whether the scientific evidence permits conclusions concerning the effect of the service on health outcomes, and whether, in the predominant opinion of the experts, as expressed in the published authoritative literature, (i) that usage should be substantially confined to research settings, or (ii) that further research is necessary, or the written protocol describes among its main objectives the necessity to determine safety, toxicity, efficacy, or effectiveness of that service compared with conventional treatment alternatives.
4. Whether the service is being delivered or should be delivered subject to the approval and supervision of an institutional review board as required and defined by federal regulations, particularly those of the Food and Drug Administration or the Department of Health and Human Services.
5. The failure rate and side effects of the treatment or procedure.
6. Whether other, more conventional methods of treatment have been exhausted.
7. Whether the service is as beneficial as any established alternatives.
8. Whether the procedure or treatment is medically necessary and is expected to improve the net health outcome of the covered individual.
9. Whether the procedure or treatment is recognized for reimbursement by *Medicare*, *Medicaid*, other insurers or self-funded plans, or other applicable third party payers.
10. Whether the procedure or treatment is a complication of an *experimental* or *investigational* service.

Procedures in question for their *experimental* or *investigational* nature will be reviewed by appropriate members of the medical profession for recommendation. To be covered, the procedure or treatment in question must not be determined to be *experimental* or *investigational*, and the covered individual must meet the criteria for treatment or other procedure with regard to age, general health, etc., and have been determined to be a good candidate for the procedure or treatment by an accredited facility. Final decisions regarding coverage under the DSGHP will be at the sole discretion of the DSGHP *Administrator*.

HIPAA: The Health Insurance Portability and Accountability Act of 1996.

Hanover NH Area: Hanover Area refers to the following zip code areas.

NEW HAMPSHIRE	VERMONT	
03741 Canaan	05043 East Thetford	05065 Sharon
03743 Claremont	05047 Hartford	05068 South Royalton
03748 Enfield	05048 Hartland	05070 South Strafford
03749 Enfield Center	05049 Hartland 4 Corners	05071 South Woodstock
03755 Hanover	05052 North Hartland	05156 Springfield
03756 Lebanon	05053 North Pomfret	05072 Strafford
03766 Lebanon	05054 North Thetford	05074 Thetford
03768 Lyme	05055 Norwich	05075 Thetford Center
03769 Lyme Center	05059 Quechee	05084 West Hartford
03770 Meriden	05060 Randolph	05001 White River Junction
03777 Orford	05061 Randolph Center	05088 Wilder
03781 Plainfield	05068 Royalton	05091 Woodstock
03784 West Lebanon		

Health Care Provider: A physician, practitioner, nurse, hospital, or specialized treatment facility as those terms are specifically defined in this section. A health care provider must not be spouse, child, or other close family relative of the DSGHP covered person receiving services. Refer also to provider/practitioner.

Home Health Care/Home Health Care Agency: A public or private agency or organization licensed and operated according to the law that specializes in providing medical care and treatment in the home. The agency must have policies established by a professional group and at least one physician and one registered graduate nurse to supervise the services provided.

Home Hospice: A program, licensed and operated according to state law, which is approved by the attending physician to provide palliative, supportive, and other related care in the home for a terminally ill covered person.

Hospice Facility: A public or private organization, licensed and operated according to the law, primarily engaged in providing palliative, supportive, and other related care for a covered person diagnosed as terminally ill. The facility must have an inter-disciplinary medical team consisting of at least one physician, one registered nurse, one social worker, one volunteer, and a volunteer program. A hospice facility is not a facility or part thereof which is primarily a place for rest, custodial care, the aged, drug addicts, alcoholics, or a hotel or similar institution.

Hospital: A public or private facility licensed and operated according to the law, which provides care and treatment by physicians and nurses at the patient's expense of an illness or injury through medical, surgical, and diagnostic facilities on its premises. A hospital does not include a facility or any part thereof which is, other than by coincidence, a place for rest, the aged, or convalescent care.

Illness: Any bodily sickness or mental/nervous disorder. For purposes of the DSGHP, pregnancy will be considered as any other illness.

Injury: A condition which results independently of an illness and all other causes and is a result of an externally violent force or accident.

Inpatient: Treatment in an approved facility during the period when charges are made for room and board.

Intensive Care Unit: A section, ward, or wing within a hospital which is operated exclusively for critically ill patients and provides special supplies, equipment, and constant observation and care by registered graduate nurses or other highly trained personnel. Intensive Care Unit does not include any hospital facility maintained for the purpose of providing normal post-operative recovery treatment or service.

Legend Drug: A Legend Drug is any drug or medication designated as "Rx Only" by the Federal Food, Drug and Cosmetic Act, as amended. Legend Drugs cannot be dispensed without prescription.

Lifetime: The period of time you or your eligible dependents participate in the DSGHP or any other health insurance plan sponsored by Dartmouth College for Dartmouth College students and/or their eligible dependents.

Medicaid: Title XIX (Grants to states for Medical Assistance Programs) of the United States Social Security Act as amended.

Medical Emergency: An *illness or injury* which occurs suddenly and unexpectedly, requiring immediate medical care and use of the most accessible *hospital* equipped to furnish care to prevent the death or serious impairment of the *covered person*. Such conditions include, but are not limited to, suspected heart attack, loss of consciousness, actual or suspected poisoning, acute appendicitis, heat exhaustion, convulsions, emergency medical care rendered in *accident* cases, and other acute conditions.

Medical Withdrawal: The policies for medical withdrawal are formally established and published by Dartmouth College. Contact the DSGHP Administrator for referral to specific Dartmouth policies and web sites.

Medically Necessary (Medical Necessity): Services or supplies which the DSGHP Administrator determines, in the exercise of its discretion, are generally acceptable by the national medical professional community as being safe and effective in treating a covered *illness or injury*, consistent with the symptoms or diagnoses, furnished at the most appropriate medical level, and not primarily for the convenience of the patient, a *health care provider*, or anyone else.

Because a *health care provider* has prescribed, ordered, or recommended a service or supply does not, in itself, mean that it is *medically necessary* as defined above.

Medicare: Title XVIII (Health Insurance for the Aged and Disabled) of the United States Social Security Act as amended.

Mental/Nervous Disorder: For purposes of the DSGHP, a mental/nervous disorder is any diagnosed condition listed in the Diagnostic and Statistical Manual of Mental Disorders (DSM, most recent edition, revised), except as specified in Excluded Expenses/Services, for which treatment is commonly sought from a psychiatrist or mental health *provider*. The DSM is a clinical diagnostic tool developed by the American Psychiatric Association and used by mental health professionals. Diagnoses described in the DSM will be considered *mental/nervous* in nature, regardless of etiology.

Mental/Nervous Treatment Facility: A public or private facility, licensed and operated according to the law, which provides: a program for diagnosis, evaluation, and effective treatment of *mental/nervous disorders*; and professional nursing services provided by licensed practical *nurses* who are directed by a full-time R.N. The facility must have a *physician* on staff or on call. The facility must also prepare and maintain a written plan of treatment for each patient. The plan must be based on medical, psychological, and social needs.

Morbid Obesity: A diagnosed condition in which the body weight exceeds the normal weight by either 100 pounds or is twice the normal weight of a person the same height, and conventional weight reduction measures have failed. The excess weight must cause a medical condition such as physical trauma, pulmonary and circulatory insufficiency, diabetes, or heart disease.

National Provider Identifier number (NPI): Identifies the provider.

Network Maximum Allowable Cost: The maximum amount that a pharmacy in the Express Scripts pharmacy network will be reimbursed for a particular prescription drug

Nurse: A person acting within the scope of applicable state licensure/certification requirements and holding the degree of Registered Graduate Nurse (R.N.) or Licensed Practical Nurse (L.P.N.).

Open Enrollment Period: The open enrollment period is either September 1 through September 30 of each plan year, or the first 30 days for new students first enrolling at Dartmouth College for periods other than September 1 through September 30.

Oral Surgery: Necessary procedures for surgery in the oral cavity, including pre- and postoperative care.

Outpatient: Treatment either outside of a *hospital* setting or at a *hospital* when room and board charges are not incurred.

Out-of-Pocket Maximum: The total cost for which a *covered person* or family may be liable under the DSGHP benefits plan for the relevant *plan year*. The *out-of-pocket maximum* is designed to protect *covered persons* from catastrophic health care expenses. For each *plan year*, after the *out-of-pocket maximum* is reached, for most services payment will be made at 100% of the allowable charge for the remainder of the *plan year*.

Pre-Service Claims: Pre-Service Claims must be submitted to the Plan before the Covered Person receives medical treatment or service. A Pre-Service Claim is any claim for a medical benefit which the Plan terms condition the Covered Person's receipt of the benefit, in whole or in part, on approval of the benefit before obtaining treatment. Pre-Service Claims are claims decisions that the Plan requires pre-authorization before a Covered Person obtains medical care.

Post-Service Claims: A Post-Service Claim is any claim for a medical benefit under the Plan with respect to which the terms of the Plan do not condition the Covered Person's receipt of the benefit, or any part thereof, on approval of the benefit prior to obtaining medical care, and for which medical treatment has been obtained prior to submission of the claim(s).

In most cases, initial claims decisions on Post-Service Claims will be made within thirty (30) days of the Plan's receipt of the claim. The Plan will provide timely notice of the initial determination once sufficient information is received to make an initial determination, but no later than thirty (30) days after receiving the claim.

Partial Hospitalization: A distinct and organized intensive ambulatory treatment service, less than 24-hour daily care, specifically designed for the diagnosis and active treatment of a *mental/nervous disorder* when there is a reasonable expectation for improvement, or to maintain the individual's functional level, and to prevent relapse or hospitalization.

Partial hospitalization programs must provide diagnostic services; services of social workers; psychiatric *nurses* and staff trained to work with psychiatric patients; individual, group, and family therapies; activities and occupational therapies; patient education; and chemotherapy and biological treatment interventions for therapeutic purposes. The facility providing the *partial hospitalization* must prepare and maintain a written plan of treatment for each patient. The plan of treatment must be approved and periodically reviewed by a *physician*.

Physician: A licensed Doctor of Medicine or Doctor of Osteopathy practicing within the scope of his or her license, and who is not a close family member of the DSGHP *covered person* receiving services.

Physically or Mentally Disabled: The inability of a person to be self-sufficient as the result of a condition such as mental retardation, cerebral palsy, epilepsy or another neurological disorder and diagnosed by a *physician* as a permanent and continuing condition.

Plan Document: This document governing the operation of the Dartmouth Student Group Health Plan for the 2015-2016 *Plan Year*.

Plan Sponsor: The Trustees of Dartmouth College

Plan Year: The 12-month period beginning September 1 and ending August 31.

Provider/Practitioner: In addition to the specific *providers/practitioners* listed in this definition, a *provider/practitioner* must also meet the requirements specified in the definition of a *health care provider*.

An appropriately licensed: *physician* (M.D.), Doctor of Dental Surgery (D.D.S.), Doctor of Dental Medicine (D.M.D.), Licensed Anesthesiologist, Doctor of Podiatry Medicine (D.P.M.), Doctor of Chiropractic (D.C.), Doctor of Optometry (O.D.), Certified Nurse Midwife (C.N.M.), Certified Registered Nurse Anesthetist (C.R.N.A.), Registered Physical Therapist (R.P.T.), Psychologist (Ph. D., Ed. D., Psy.D., MA), Registered Nurse (R.N.), Licensed Clinical Social Worker (L.C.S.W.), Master of Social Work (M.S.W.), Speech Therapist, Christian Science Practitioner or Nurse, Occupational Therapist, Physician's Assistant, Registered Dietician (R.D.), Registered Respiratory Therapist, Nutritionist, Nurse Practitioner (A.R.N.P.), Naturopath (N.D.), or Pastoral Counselor.

Preferred Allowance: The amount a *preferred provider* will accept as payment in full for *Covered Expenses/Services*.

Preferred Provider(s)/Preferred Provider Organization (PPO) (In-Network Providers): *Preferred provider organization* or PPO means the *physicians, hospitals, and other practitioners* who have contracted with the DSGHP to provide specific medical care services at negotiated prices.

Psychiatric Day Treatment Facility: A public or private facility, licensed, and operated according to the law, which provides: treatment for all its patients for not more than eight hours in any 24-hour period; a structured psychiatric program based on an individualized treatment plan that includes specific attainable goals and objectives appropriate for the patient; and supervision by a *physician* certified in psychiatry by the American Board of Psychiatry and Neurology.

The facility must be accredited by the Program for Psychiatric Facilities or the Joint Commission on Accreditation of Hospitals.

Reconstructive Surgery: A procedure performed to restore the anatomy and/or functions of the body, which are lost or impaired due to *injury or illness*.

Rehabilitation Facility: A legally operating institution or distinct part of an institution which has a transfer agreement with one or more *hospitals*, and which is primarily engaged in providing comprehensive multi-disciplinary physical restorative services, post-acute *hospital*, and rehabilitative *inpatient* care, and which is duly licensed by the appropriate government agency to provide such services.

It does not include institutions which provide only minimal care, *custodial care*, ambulatory or part-time care services, or an institution which primarily provides treatment of *mental/nervous disorders*, substance abuse, or tuberculosis, except if such facility is licensed, certified, or approved as a *rehabilitation facility* for the treatment of mental/nervous conditions or substance abuse in the jurisdiction where it is located, or is accredited as such a facility by the Joint Commission for the Accreditation of Health Care Organizations or the Commission for the Accreditation of *Rehabilitation Facilities*.

Residential Treatment Facility: A child-care institution that provides residential care and treatment for emotionally disturbed children and adolescents. The facility must be accredited as a *residential treatment facility* by the Council on Accreditation, the Joint Commission on Accreditation of Hospitals, or the American Association of Psychiatric Services for Children.

Second Surgical Opinion: Examination by a *physician* who is certified by the American Board of Medical Specialists in a field related to the proposed *surgery* to evaluate the medical advisability of undergoing a surgical procedure.

Skilled Nursing Facility: A public or private facility, licensed and operated according to the law, which provides: permanent and full-time facilities for 10 or more resident patients; a registered *nurse* or *physician* on full-time duty in charge of patient care; at least one registered *nurse* or licensed practical *nurse* on duty at all times; a daily medical record for each patient; transfer arrangements with a *hospital*; and a utilization review plan.

The facility must be primarily engaged in providing continuous skilled nursing care for persons during the convalescent stage of their *illness* or *injury*, and is not, other than by coincidence, a rest home for *custodial* care or for the aged.

Specialized Treatment Facility: A *specialized treatment facility*, as the term relates to the DSGHP, includes *birthing centers*, *ambulatory surgical facilities*, *hospice facilities*, *skilled nursing facilities*, *mental/nervous treatment facilities*, Christian Science sanitariums, chemical dependency/substance abuse day treatment facilities, *psychiatric day treatment facilities*, *substance abuse treatment facilities*, and *rehabilitation facilities* as those terms are specifically listed in *Covered Expenses/Services*.

Surgery: Any operative or diagnostic procedure performed in the treatment of an *injury* or *illness* by instrument or cutting procedure through any natural body opening or incision.

Third Surgical Opinion: Examination by a *physician* who is certified by the American Board of Medical Specialists in a field related to the proposed *surgery* to evaluate the medical advisability of undergoing a surgical procedure.

Total Disability (Totally Disabled): A student will be considered *totally disabled* if, because of a non-occupational *injury* or *illness* that first became manifest while covered under the DSGHP, he or she is prevented from attending class or completing other required school work. The determination of *total disability* must be authorized by a *physician* employed by Dartmouth College Health Services. The authorization for *total disability* must be reauthorized by Dartmouth College Health Services at the beginning of a new plan year if the 12 month extension of benefits extends beyond the plan year in which the disabling condition first became manifest.

Urgent Care Claims: An Urgent Care Claim is any claim for medical care or treatment with respect to which:

1. In the judgment of a prudent layperson possessing an average knowledge of health and medicine could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function; or
2. In the opinion of a Physician with knowledge of the claimant's medical condition, would subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

Usual and Customary Charge: The charge most frequently made by a *health care provider* to the majority of patients for the same service or procedure, and the charge must be within the range of the charges most frequently made in the same or similar medical service area for the service or procedure as billed by other *health care providers*.

GENERAL INFORMATION

DSGHP Advisory Committee

Since 1994, the DSGHP Advisory Committee has provided community input into the design and programming of the Dartmouth Student Group Health Plan (DSGHP).

The Committee meets each spring during the Plan's annual review to provide advice and recommendations for the next plan year.

Advisory Committee Members

Dr. Mark Reed, Director, Health Service
Ben Strum, PharmD, Operation Supervisor, Integrated Pharmacy Solutions
Heather Earle, PhD, Director of Counseling & Human Development, Health Service
Dr. Ann Bracken, MD, PhD, PCPM Director, Health Service
David Leenders, Associate Director of Health Services, Director of Finance and Administration
Tricia Spellman, Assistant VP for Finance
David Foster, Manger, Claims & Loss Control, Risk & Internal Controls Services
Diana Kiefer, Finance Manager, Health Service
Pam Mobilia, PCPM Office Manager, Health Service
Gary Hutchins, Asst. Dean of Graduate Studies
Marcia Calloway, Assoc. Director, Advisor to International Students, OVIS
Ginger Farewell Lawrence, DSGHP & Patient Accounts Manager, Health Service
G. Dino Koff, Associate Dean for Student Services and Admissions, Director of Financial Aid,
Geisel School of Medicine at Dartmouth

~Healthcare Management & Benefit Consultants

Teresa Koster, Division President Gallagher Student Health and Special Risk

Name and Address of the Designated Agent for Service of Legal Process

Dartmouth College Health Service
Office of the Director of Health Services
7 Rope Ferry Road
Hanover, New Hampshire 03755
603-646-9486

Name and Mailing Address of the DSGHP

Dartmouth College Health Service
Office of the DSGHP
7 Rope Ferry Road
Hanover, New Hampshire 03755
603-646-9438

Address of the DSGHP Trustees

The Trustees of Dartmouth College
Office of the President
Dartmouth College
209 Parkhurst Hall
Hanover, New Hampshire 03755

DSGHP Staff



Ginger Farewell Lawrence
Manager

Ginger joined the DSGHP staff
the spring of 1993.



Michelle Murray
Administrative Assistant

Michelle joined the DSGHP
staff the summer of 2010.



Tracy Wallace
Administrative Assistant

Tracy joined the DSGHP staff
the spring of 2015.