

2018-2019

Dartmouth Student Group Health Plan (DSGHP)

Plan Document

Effective Date: September 1, 2018



Photo: B. Murray

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Hanover, NH 03755-1421

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For The Most Current
Information Regarding The
Plan, Notices & General
Information, Refer To The
DSGHP Website
dartgo.org/studentinsurance

IMPORTANT INFORMATION

THIS DOCUMENT REFLECTS THE KNOWN REQUIREMENTS FOR COMPLIANCE UNDER THE AFFORDABLE CARE ACT AS PASSED ON MARCH 23, 2010. AS ADDITIONAL GUIDANCE IS FORTHCOMING FROM THE US DEPARTMENT OF HEALTH AND HUMAN SERVICES, AND THE NEW HAMPSHIRE INSURANCE DEPARTMENT, THOSE CHANGES WILL BE INCORPORATED INTO THE HEALTH INSURANCE DOCUMENT.

TABLE OF CONTENTS

Introduction	3
Eligibility & Participation	4-5
Enrollments	5-6
Effective Dates	6-7
Contact Information	8
Medical Benefits & Requirements	9-16
Benefits for Services from Dartmouth College Health Service	9
PPO Network Benefits	9
Deductibles, Co-payments & Co-insurance	10
Plan Maximums	11
DSGHP Benefit Chart	12-13
PPACA Preventive Care Benefits	14
Covered Preventive Services for Adults	14
Covered Preventive Services for Women and Children	14
General Requirements	15
Health Care Management Program & Notification Requirements	15
Medical & Substances Abuse Case Management	16
Covered Expenses & Services	17-26
College Provided International Travel Benefit	27
Excluded Expenses & Services	28-29
Prescription Drug Benefits	30-31
General Requirements & Covered Drugs	30
Dispensing Limits & Excluded Drugs	31
Dental Savings Program	32
Pediatric Dental and Vision benefits	32-34
Other Important Plan Provisions	34-36
Claim Procedures	36-42
How to File a Medical Claim	38
How to File a Prescription Claim	38
How to Appeal a Denial of Benefits	39-42
Plan Definitions	43-48
General Information	49
DSGHP Staff	50
State of NH Consumer Guide to Appeal	51-64

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.

Dartmouth College Nondiscrimination policy may be found at
http://www.dartmouth.edu/~health/docs/2017_2018_dartmouth_college_dsghp_non_discrimination_notice.pdf

INTRODUCTION

Welcome to the Dartmouth Student Group Health Plan (DSGHP). Dartmouth College has prepared this document to help you understand your medical and prescription drug benefits as a participant in the DSGHP. This document replaces any document that may have been given to you in the past. Please read it carefully.

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.

As used in this document, the term plan year is the twelve (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, 2018.



**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 protected health information (PHI) should not be sent by email.

ELIGIBILITY AND PARTICIPATION

Student Eligibility

You are eligible for coverage through the DSGHP only if enrolled in the DSGHP, and you are considered by Dartmouth College to be one of the following:

- An active* undergraduate student, making progress toward a Dartmouth degree.
- An active* student enrolled in a Dartmouth Exchange Program, during the academic terms of Dartmouth Exchange Program enrollment only.
- An active* non-Dartmouth student (exchange student from another college or university), during the academic terms of Dartmouth enrollment only.
- An active* graduate student, making progress toward a Dartmouth degree.

* An active student is a student who is designated as active in the Dartmouth Student Information System with the approval of the appropriate Dean.

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 spouse or domestic partner.
- A child* younger than age twenty-six (26).
- A physically or mentally disabled child* of any age, provided the disability began before he or she reached age twenty-six (26) and while covered under the DSGHP. Coverage may continue for as long as the child* remains disabled, 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 is defined as any of the following relationships to a DSGHP-covered student:

- Your biological child, or child for whom you are required to provide coverage under court order.
- A legally adopted child by you.
- 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 adoptions becomes final.
- A foster child.
- A stepchild or child of your domestic partner.

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.

ENROLLMENTS

Student Enrollment

Active students are automatically enrolled in the DSGHP unless a waiver is submitted and approved 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 the When Coverage Begins section.

Dependent Enrollment

To obtain immediate coverage under the DSGHP, you must enroll your eligible dependents in the DSGHP within thirty-one (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 thirty-one (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. Dependent enrollment is not automatic, and a new Dependent Application must be submitted every plan year. Coverage will become effective as described in the When Coverage Begins section.

Your newborn child (born to either a male or female DSGHP-covered parent) is automatically covered for the first thirty-one (31) days following and including the date of birth. For coverage to continue beyond the thirty-one (31) days, you must notify the DSGHP by submitting a Dependent Application and pay any required prorated premium. If you fail to do so, coverage will terminate at the end of the thirty-one (31) days.

Late Enrollment and Mandatory Enrollment of Uninsured

If you lose coverage under an individual or group health plan, you may enroll yourself (and any qualifying dependents) in the DSGHP as of the date the other coverage ends. To do this, you must provide a Midyear Enrollment form and documentation of the loss of coverage within thirty-one (31) days of losing that coverage, and if applicable a Dependent Application. The DSGHP premium will be prorated based on the date of enrollment.

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 automatically enrolled in the DSGHP from the date they are determined by Dartmouth College to be without health insurance coverage. The student will not be eligible for a prorated premium and will be required to pay for the full annual premium for the DSGHP.

For DSGHP enrollees only – If your dependent loses coverage under an individual or group health plan, you may enroll your dependent in the DSGHP as of the date the other coverage ends. To do this, you must provide a Dependent Application and documentation of the loss of coverage within thirty-one (31) days of losing that coverage. The DSGHP premium will be prorated based on the date of enrollment.

Late enrollments are subject to all limitations, provisions, and requirements of the DSGHP.

EFFECTIVE DATES

When Coverage Begins

Coverage begins on August 1 for newly enrolled students and on September 1 for returning students. For students starting at Dartmouth at a later term, please contact the DSGHP office for coverage dates.

- First-year International Students with F/J visa status will have an effective date thirty (30) days prior to their first term at Dartmouth College.

Dependent coverage begins on September 1. First-year students may enroll their qualifying dependents on August 1 for an additional fee. Please contact the DSGHP office for information.

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 are no longer eligible for the DSGHP coverage.
- The date your Extension of Eligibility program expires, if you purchase this program as described below.
- 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 if you complete your degree requirements at the end of Fall or Winter terms 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 online waiver form. Your midyear waiver must be submitted by the fifteenth (15th) of the cancellation month (December/March) in order to be effective that month.

When Dependent(s) Coverage Ends

- Coverage for your dependent(s) will end on the date your coverage ends or the date the dependent ceases to be an eligible dependent, whichever comes first.
- December 31 or March 31, by completing a Midyear Cancellation form.

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. This Extension of Eligibility provision does not apply to students who did not have student status immediately preceding the loss of DSGHP eligibility.
2. If you 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.

Notwithstanding the foregoing, if a physician certifies that a student is totally disabled by the date coverage under the DSGHP would otherwise end, only Covered Expenses/Services directly related to the total disability will be processed under the terms and conditions of the plan. 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.

You must apply for the Extension of Eligibility and pay the premium for DSGHP coverage within thirty-one (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

CONTACT INFORMATION

Assistance regarding enrollment, plan benefits, claims procedures, and required notifications are 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

Phone: 844-206-0372

Prior Notification of Hospital Admissions: 877-202-6379

Web: <http://healthsmart.com/dartmouthcollege.aspx>

Email: akronclaims@HealthSmart.com

Pharmacy Processor

HealthSmart Rx

3320 West Market Street
Fairlawn, OH 44333

Member and Pharmacy Phone: 800-681-6912

PPO Network & Medical Claim Submission

Cigna PPO

PO Box 188061
Chattanooga TN 37422-8062

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

Medical: <https://hcpdirectory.cigna.com/web/public/providers>

Eye Care: <https://cigna.vsp.com/find-a-doctor.html>

Mental Health: <https://apps.cignabehavioral.com/web/consumer.do#/findAtherapist>

Basix Dental Savings Program

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

Emergency Travel Assist Service

International SOS

Scholastic Members Phone: 215-942-8478

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

Benefits for Services from Dartmouth College Health Service

For services received at Dartmouth College Health Service, DSGHP will pay 100% of expenses, excluding the following:

- Durable medical equipment & supplies
- Labs sent to and billed by an outside facility (these will be processed under the Terms and Conditions of the Plan).

PPO Network Benefits

In-network providers are the physicians, hospitals, and other healthcare 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 a deductible, co-payment, and coinsurance provisions). You identify your eligibility for in-network charges by showing your health plan Identification Card at the time of your visit.

Please be aware that PPO Network hospitals may be staffed with physicians and other professional staff who are not in the PPO Network. Unless otherwise specified, 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

There are three ways you can find out if a Provider of Facility is in the Cigna PPO network;

1. See Cigna's PPO directory of in-network providers at:
 - a. Medical: <https://hcpdirectory.cigna.com/web/public/providers>
 - b. Eye Care: <https://cigna.vsp.com/find-a-doctor.html>
 - c. Mental Health: <https://apps.cignabehavioral.com/web/consumer.do#/findAtherapist>
 2. Call Customer Service to ask for a list of doctors and providers that participate in the Cigna PPO network, based on specialty and geographic area. The toll-free Customer Service telephone number is 1-866-459-4272.
 3. Check with your doctor or provider.
- Pharmacy Network: <http://healthsmart.com/dartmouthcollege.aspx>

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

If you choose to use a provider that is not a member of the PPO Network, this will increase your out-of-pocket costs. Generally, after you satisfy the out-of-network deductible, when applicable, the DSGHP will pay the percentage of usual and customary charges shown in the DSGHP Benefits Chart.

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

Your share of the costs of a covered health care service, calculated as a percentage (for example, 20%) of the allowed amount for the service. You generally pay coinsurance plus any deductibles you owe. (For example, if the health insurance or plan's allowed amount for an office visit is \$100 and you've met your deductible, your coinsurance payment of 20% would be \$20. The health insurance or plan pays the rest of the allowed 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 an out-of-network physician at an in-network hospital will be paid at the in-network level, with no balance billing for anesthesiology, radiology, emergency medicine or pathology services.

Out-Of-Pocket Maximum

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.
- Premium

The plan year individual and family Out-of-Pocket Maximum amounts are shown in the DSGHP Benefit Chart. Any amount applied toward the PPO Network Out-of-pocket maximum will also 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 benefit maximums. A benefit maximum can apply to specific benefit categories or to all benefits. A benefit maximum 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 DSGHP Benefit Chart. 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



2018 – 2019 DSGHP 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 Hall's House Pharmacy, Dartmouth-Hitchcock Pharmacy or Dartmouth-Hitchcock Pharmacy at Centerra)	\$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 (Plan pays)	Out-of-Network (Plan pays)
	Referral required from Dartmouth College Health Service if in the Hanover, NH area. Without a referral, benefits will be processed at the out-of-network level.	
Preventive Care Services (If in Hanover, NH area: Services received at Dartmouth College Health Service, or with a referral if services are not available at Dartmouth College Health Service.)	100%	Not Covered
Services at Dartmouth College Health Service (Except for certain medical equipment & supplies, and labs)	100%	N/A
Emergency Room Services (Co-payment waived if admitted.)	100% after \$100 co-payment	
Ambulance	100% after \$100 co-payment	
Outpatient Mental/Nervous and Substance Abuse Treatment	90%; no deductible	80% of usual and customary charges; no deductible
Learning Disability Testing (100% coverage for first \$1500)	90%; no deductible	80% 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
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 (Referral from Dartmouth College Health Services is required. Covered Medical Expenses are payable on the same basis as any other condition.)	80% after deductible	70% of Usual and Customary charges after deductible
Lifetime Individual Maximum for All Benefits (Unless otherwise specified.)	Unlimited	
National Collegiate Athletic Association (NCAA) Sanctioned Intercollegiate Sports Injuries (The DSGHP is primary for the first \$90,000 of eligible expenses per injury, and is secondary to coverage under the NCAA catastrophic policy for eligible expenses in excess of \$90,000 per injury.)	80% after deductible	70% of Usual and Customary charges after deductible
Club Sports Injuries (The DSGHP is primary for the first \$30,000 of eligible expenses per injury and secondary to coverage provided under the Club Sport catastrophic policy for eligible expenses in excess of \$30,000 per injury.)	80% after deductible	70% of Usual and Customary charges after deductible

Pharmacy Benefit Description	In-Network (Plan pays)	Out-of-Network (Plan pays)
Dick Hall's House Pharmacy, Dartmouth-Hitchcock Pharmacy and Dartmouth-Hitchcock Pharmacy at Centerra (Not subject to prescription plan year deductible. \$5 Generic drug copayment per 30-day prescription, \$15 brand name and/or specialty drug copayment per thirty (30) day prescription, 100% coverage for generic contraception medication and medically necessary brand name and/or specialty contraception medication. If receiving a ninety (90) day supply, there will be a \$10 copayment for generic drugs and a \$30 copayment for brand name and/or specialty drugs.)	N/A	
Other Pharmacies	80% HealthSmart Rx participating pharmacies, 100% coverage (not subject to the prescription plan year deductible) for generic contraception medication and medically necessary brand name and/or specialty 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 ninety (90) day supply. Other dispensing limits may be imposed as required by federal or state regulation for other reasons.		

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 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.

For services received at Dartmouth College Health Service or at an in-network provider, PPACA Preventive Care Benefits are processed or reimbursed at 100% as specified in the DSGHP Benefit Chart.

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

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 websites for updates.

Covered Preventive Services for Adults

<https://www.healthcare.gov/preventive-care-adults/>
<https://www.cdc.gov/vaccines/hcp/acip-recs/index.html>
<https://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/>

Services for Pregnant Women or Women who may become Pregnant and Other Preventive Services for Women

<https://www.healthcare.gov/preventive-care-women/>
<https://www.cdc.gov/vaccines/hcp/acip-recs/index.html>
<https://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/>

Covered Preventive Services for Children

<https://www.healthcare.gov/preventive-care-children/>
<https://www.cdc.gov/vaccines/hcp/acip-recs/index.html>
<https://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/>

MEDICAL BENEFITS AND REQUIREMENTS

General Requirements & Guidelines

(For services received outside of the Dartmouth College Health Service)

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 referral from the Dartmouth College Health Services. These requirements do not apply to your dependent children, maternity expenses or Eye & Hearing Examination expenses incurred outside of the Hanover NH Area.
2. 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 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, maternity expenses or Eye & Hearing Examination expenses incurred outside of the Hanover NH Area.
3. A recommendation by a non-Health Service Provider for follow-up care does not meet the DSGHP's referral requirement. Services received within forty-five (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 forty-five (45) day period, a referral is required from the Dartmouth College Health Service.
4. A referral from Dartmouth College Health Service is required for Sleep Disorder and Sleep Disorder testing.
5. You must notify the DSGHP, as described under the Health Care Management Program's prior notification of hospital admission requirement, of elective admissions to a hospital, hospice facility, or skilled nursing facility, and before receiving any home health care or home hospice services.
6. The DSGHP will only provide benefits 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.
7. The DSGHP will only provide benefits 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 are also increased for Non-PPO-Network Provider services.
8. The DSGHP will only provide benefits 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 retains 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

Prior to 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 notify HealthSmart by calling their toll-free number (877-202-6379). You must also call within forty-eight (48) hours (two (2) working days) following any emergency admission. When you call, it will be necessary to provide the subscriber's name, 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.

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 healthcare 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 healthcare professional. If appropriate, you will be assigned a case manager who will assist you in examining your healthcare 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.

COVERED EXPENSES/SERVICES

This section describes the covered services available under the Plan. Covered services are subject to all the terms and conditions described in this Plan Document, including but not limited to, benefit maximums, deductibles, copayments, coinsurance, and exclusions. Please read the DSGHP Benefit Chart for information on the amounts the Plan will pay for covered services and for information on any benefit maximums. Also be sure to read the “Excluded Expenses/Services” section for important details on excluded benefits and services.

Benefits may vary depending on where you choose to get Covered Services, and this can result in a change in the amount you need to pay. Please see the DSGHP Benefits Chart for more details on how benefits vary.

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 DSGHP Benefits Chart 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 as specified under the 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 DSGHP 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.

Medical Equipment and Supplies

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.

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. Breast Pump (limited to one pump per pregnancy, as specified under the Preventive Care Benefits.)
4. Compression therapy garments (e.g., Jobst garments).
5. Durable medical equipment, including expenses related to necessary repairs and maintenance.
6. Enteral Formula and modified low protein food products. (enteral pumps and related equipment and supplies)
7. 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.
8. Insulin infusion pumps.
9. 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.
10. Orthotics, orthopedic or corrective shoes, and other supportive appliances for the feet.
11. Oxygen and rental of equipment required for its use, not to exceed the purchase price of such equipment.
12. Sterile surgical supplies after surgery.
13. 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.

Medical Services

1. Acupuncture.
2. Allergy testing and treatment, including allergy sera.
3. Cardiac Rehabilitation. Benefits are available for Outpatient cardiac rehabilitation programs and include exercise and education under the direct supervision of skilled program personnel in the intensive rehabilitation phase of the program. The rehabilitation program must start within three months of the diagnosis/procedure, or enrollment into the plan, whichever is later. The rehabilitation program must be completed within six months of the diagnosis/procedure, or enrollment into the plan, whichever is later

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 ten (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. 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 an 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).

7. Dental services received after an accidental injury to teeth, excluding biting or chewing injuries. This includes replacement of teeth and any related X-rays.

8. Dialysis.

9. 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.

10. 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.

11. 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 twelve (12) ovulation cycles in a period of up to twenty-four (24) consecutive months, as medically documented. For women over age thirty-five (35), infertility may be suspected after a woman's uterus has had contact with sperm during six (6) ovulation cycles in a period of up to twelve (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, as well as treatment of the underlying medical conditions that cause infertility (e.g., endometriosis, obstructed fallopian tubes, and hormone deficiency):

- 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, micro fertilization (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.

12. Home health care provided by a home health care agency.

13. Home hospice.

14. Hormone replacement therapy for peri- and post-menopausal women and hormone therapy for the treatment of gender identity disorders.

15. Inpatient/Outpatient Rehabilitation Services:

- Occupational therapy to restore a physical function or for rehabilitative therapy
- Physical therapy from a qualified practitioner, for restorative or rehabilitative therapy
- Speech therapy from a qualified practitioner to restore speech loss due to an illness, injury, or surgical procedure, or for rehabilitative therapy.

16. Inpatient visits by the attending physician.

17. 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 one hundred (100) percent when received in-network, as specified under the Preventive Care Benefits.

18. 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. Please refer to the DSGHP Benefit Chart for coverage details.

Treatment for learning disabilities, including 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.

19. Learning disability testing expenses for DSGHP Covered Children, for 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). Please refer to the DSGHP Benefit Chart for coverage details.

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. Physician home and office visits.
25. Pregnancy-related care.
26. Routine hearing exams to determine the need for hearing correction or hearing aids payable as preventive care services in the DSGHP Benefits Chart (one exam each plan year for covered persons 18 years old and younger; one exam every two (2) years for covered persons nineteen (19) years old and older.)
 - Hearing Aids: Benefits are available for one hearing aid per ear each time a hearing aid prescription changes.
27. Routine vision examinations from an optometrist or ophthalmologist payable as preventive care services in the DSGHP Benefits Chart (one exam each plan year for covered persons eighteen (18) years old and younger; one exam every two(2) years for covered persons nineteen (19) years old and older.) This includes dilation and refraction, as needed.
28. 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 ten (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.
29. Second and/or Third surgical opinions.
30. Speech therapy from a qualified practitioner to restore speech loss due to an illness, injury, or surgical procedure, or for habilitative therapy.
31. Termination of pregnancy.
32. Titters when medically necessary, or for routine testing of the following only:
 - Hepatitis B
 - Mumps
 - Rubella (German Measles)
 - Rubeola (Measles)
 - Varicella-Zoster (Chicken Pox/Shingles)
33. Treatment of complications arising from any non-covered surgery or procedure.

34. Treatment of diabetes including diabetic education.
35. Treatment of sleep disorders and sleep studies. (Referral needed in the Hanover NH area)

Mental/Nervous and Chemical/Substance Abuse Services

1. Applied Behavioral Health
2. Bereavement counseling.
3. Biologically Based Mental Illnesses.
 - Schizophrenia and other psychotic disorders
 - Schizoaffective disorder
 - Major depressive disorder
 - Bipolar disorder
 - Anorexia nervosa and bulimia nervosa
 - Obsessive-compulsive disorder
 - Panic disorder
 - Pervasive developmental disorder or autism
 - Chronic post-traumatic stress disorder
4. Inpatient treatment of chemical/substance abuse and/or a mental/nervous disorder.
5. Marital, couples, and family counseling.
6. Outpatient treatment of chemical/substance abuse and/or a mental/nervous disorder.
7. Partial hospitalization (applies to inpatient benefits as a half day).
8. Treatment of or related to an eating disorder.
9. 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 DSGHP Benefits Chart.
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.
 - a. This includes the administration of general anesthesia by a licensed anesthesiologist or anesthetist for dental procedures performed on a covered person who:
 - i. Is a child under the age of six (6) who is determined by a licensed dentist in conjunction with a licensed physician to have a dental condition of significant dental complexity which requires certain dental procedures to be performed in a surgical daycare facility or hospital setting; or
 - ii. Is a person who has exceptional medical circumstances or a developmental disability as determined by a licensed physician which place the person at serious risk.
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, facelift, 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 reductions.

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:

- all stages of reconstruction of the breast on which the mastectomy has been performed;
 - surgery and reconstruction of the other breast to produce a symmetrical appearance;
 - 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, advanced Hodgkin's lymphoma, advanced non-Hodgkin's lymphoma, advanced 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 ten (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:
 - Made necessary by accidental injury; or
 - Necessary for reconstruction or restoration of a functional part of the body following a covered surgical procedure for disease or injury; or
 - Medically Necessary to restore or improve a bodily function, or
 - 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:

- Mastectomy for Gynecomastia
- Mandibular/Maxillary orthognathic surgery
- 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.

Gender Reassignment

Requirements:

Gender reassignment surgery is considered medically necessary treatment of gender dysphoria when the individual is age eighteen (18) years or older and when the following criteria are met:

- For initial mastectomy or breast reduction:
 - one letter of support from a qualified mental health professional.
- For hysterectomy, salpingo-oophorectomy, orchiectomy:
 - documentation of at least twelve (12) months of continuous hormonal sex reassignment therapy AND
- For hysterectomy, salpingo-oophorectomy, orchiectomy:
 - documentation of at least twelve (12) months of continuous hormonal sex reassignment therapy AND
 - recommendation for sex reassignment surgery (i.e., genital surgery) by two qualified mental health professionals with written documentation submitted to the physician performing the genital surgery. (If the first referral is from the individual's psychotherapist, the second referral should be from a person who has only had an evaluative role with the individual. Two (2) separate letters, or one letter signed by both [for example, if practicing within the same clinic] are required.)
- For reconstructive genital surgery:
 - documentation of at least twelve (12) months of continuous hormonal sex reassignment therapy AND
 - recommendation for sex reassignment surgery (i.e., genital surgery) by two qualified mental health professionals with written documentation submitted to the physician performing the genital surgery. (If the first referral is from the individual's psychotherapist, the second referral should be from a person who has only had an evaluative role with the individual. (2) separate letters, or one letter signed by both [for example, if practicing within the same clinic] are required) AND
 - documentation the individual has lived for at least twelve (12) continuous months in a gender role that is congruent with their gender identity.
- Referral from Dartmouth College Health Service.

Covered Expenses:

Medically necessary treatment for an individual with gender dysphoria, including the following services:

- Behavioral health services, including but not limited to, counseling for gender dysphoria and related psychiatric conditions (e.g., anxiety, depression)
- Hormonal therapy, including but not limited to androgens, anti-androgens, GnRH analogues, estrogens, and progestins.
- Laboratory testing to monitor prescribed hormonal therapy
- Age-related, gender-specific services, including but not limited to preventive health, as appropriate to the individual's biological anatomy (e.g., cancer screening [e.g., cervical, breast, prostate]; treatment of a prostate medical condition)
- Hair removal/hair transplantation
- Gender reassignment and related surgery.
 - Initial mastectomy, breast reduction, nipple-areola reconstruction (related to mastectomy or post-mastectomy reconstruction)
 - Hysterectomy and salpingo-oophorectomy
 - Female to male reconstructive genital surgery which may include any of the following:

- Vaginectomy/colpectomy
- Vulvectomy
- Metoidioplasty
- Phalloplasty Penile prosthesis (noninflatable / inflatable), including surgical correction of malfunctioning pump, cylinders, or reservoir
- Urethroplasty/urethromeatoplasty
- Male to female reconstructive genital surgery, which may include any of the following:
 - Vaginoplasty*, (e.g, construction of vagina with/without graft, colovaginoplasty)
 - Penectomy
 - Vulvoplasty, (e.g., abiaplasty, clitoroplasty, penile skin inversion)
 - Repair of introitus
 - Coloproctostomy
- Orchiectomy

Exclusions:

Cosmetic and/or Not Medically Necessary:

- Abdominoplasty
- Blepharoplasty
- Breast augmentation with implants
- Calf implants
- Cheek/malar implants
- Chin/nose implants
- Collagen injections
- Electrolysis
- Face/forehead lift
- Facial bone reduction (osteoplasty)
- Insertion of testicular prosthesis
- Jaw reduction
- Laryngoplasty
- Mastopexy
- Neck tightening
- Nipple/areola reconstruction (unrelated to mastectomy or post-mastectomy reconstruction)
- Pectoral Implants
- Removal of redundant skin
- Replacement of tissue expander with permanent prosthesis testicular insertion
- Rhinoplasty
- Scrotoplasty
- Skin resurfacing (e.g., dermabrasion, chemical peels)
- Suction assisted lipoplasty, lipofilling, and/or liposuction
- Testicular expanders, including replacement with prosthesis, testicular prosthesis
- Thyroid reduction chondroplasty
- Voice modification surgery
- Voice therapy/voice lessons

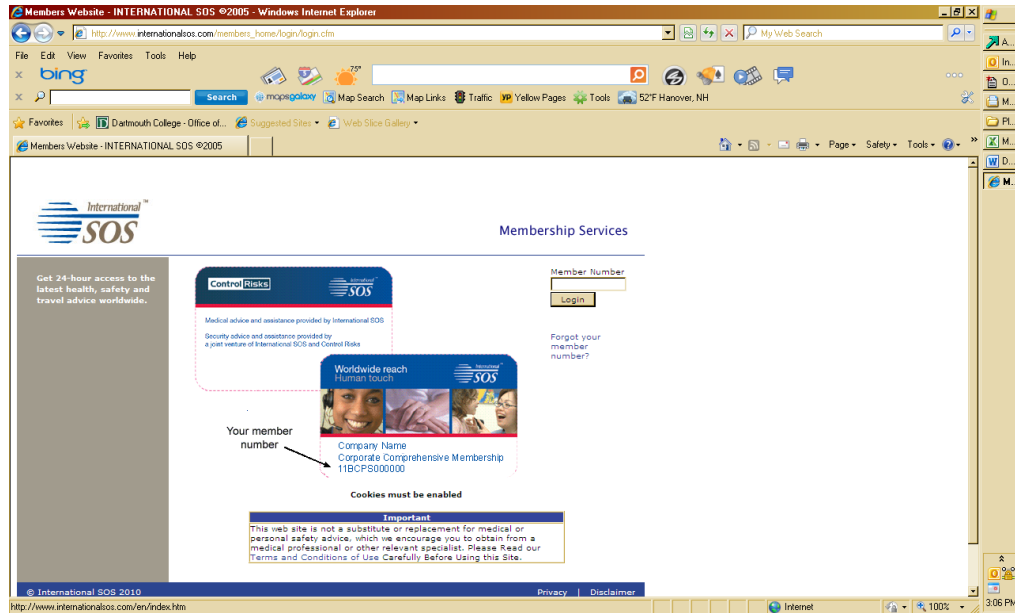
Fertility Preservation:

- Cryopreservation of embryo, sperm, oocytes
- Cryopreservation of immature oocytes
- Cryopreservation of reproductive tissue (i.e., ovaries, testicular tissue)
- Procurement of embryo, sperm, oocytes
- Storage of embryo, sperm, oocytes
- Storage of reproductive tissue (i.e., ovaries, testicular tissue)
- Thawing of reproductive tissue (i.e., ovaries, testicular tissue)

Travel Outside of the United States

To assist Dartmouth travelers in coping with the risks of travel, Dartmouth has partnered with [International SOS](http://www.internationalsos.com) to provide travel, medical, and security assistance. Services range from telephone advice, medical referrals, legal aid, to full-scale evacuation by private air ambulance. The ISOS network of five thousand (5,000) employees, including multilingual critical care and aero-medical specialists, operate twenty-four (24) hours a day, three hundred sixty-five (365) days a year from over twenty-six (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 a 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 or 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 the treatment of diabetes and Smoking Cessation.
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 more than 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, unless medically necessary.
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. Experimental/investigational equipment, services, or supplies.
21. 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.
22. Genetic counseling, except as specifically provided under Preventive Care Services.
23. Genetic testing, except as specifically provided under Preventive Care Services.
24. Hair removal, except as specifically approved by Dartmouth College Health Services.
25. Hypnosis.
26. Mailing and/or shipping and handling expenses.

27. Massage therapy or Rolfing.
28. Orthognathic surgery.
29. Penile prosthetic implants.
30. Personal comfort or service items while confined in a hospital, such as, but not limited to, radio, television, telephone, and guest meals.
31. Reversal of any reproductive sterilization procedure.
32. Routine PAP tests, routine physical exams, vaccinations, inoculations, or immunizations, except as specified in Covered Expenses/Services or Preventive Care Services.
33. Sales tax.
34. Services for or related to reconstructive surgery or cosmetic health services, except as specified in the DSGHP Benefits Chart.
35. 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
36. Services, supplies or benefits as required due to present service of any DSGHP-covered person's services in the armed forces of any government.
37. Services or supplies that are primarily and customarily used for a non-medical purpose, or used for environmental control or enhancement (whether prescribed by a physician or not), 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.
38. Services related to Dental or oral surgery, except as specified in the DSGHP Benefits Chart or accept as specifically provided under Preventive Care Services. (The plan covers surgical removal (extraction) of erupted teeth before radiation therapy for malignant diseases.)
39. Services, supplies, or treatments which are not medically necessary.
40. Sex change surgery, except as specifically provided under Covered Expenses/Services.
41. Sex counseling.
42. Surgical impregnation procedures.
43. Bariatric surgery, unless medically necessary, for the treatment of diseases and ailments caused by or resulting from obesity or morbid obesity.
44. Surrogate expenses.
45. Travel expenses of a covered person other than local ambulance services to the nearest medical facility equipped to treat the illness or injury, except as specified in the DSGHP Benefits Chart.
46. Travel expenses of a physician.
47. Treatment not prescribed or recommended by a health care provider.
48. Titters for routine testing, except as specifically provided under Preventative Care Services and Covered Services/Expenses.

PRESCRIPTION DRUG BENEFITS

General Requirements

Prescription drugs must be approved by the Food and Drug Administration (FDA) and, under federal law, require a prescription from a licensed provider. Benefits are payable for covered drugs and refills, devices and supplies when dispensed by licensed pharmacists. Although a physician's prescription is required, fulfilling this requirement does not guarantee that a particular drug will be covered. Benefits are available for prescription drugs prescribed for off-label use if recognized for treatment of the indication in one of the standard reference compendia; or in the medical literature, as recommended by current American Medical Association policies. However, no benefits are available for a drug prescribed for off-label use if the FDA has determined its use to be contraindicated for the prescribed use.

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

When you fill a covered prescription at a Network Pharmacy and show your Plan Identification card with the HealthSmart Rx 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 HealthSmart Rx for reimbursement.

Non- HealthSmart Rx 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.

For Prescription Claim Forms, the formulary (list of covered drugs), and where to find a participating pharmacy, please visit:
<http://healthsmart.com/dartmouthcollege.aspx>.

Covered Drugs

When all of the provisions of the DSGHP are satisfied, the DSGHP will provide benefits as specified in the DSGHP Benefit Chart for the following medically necessary covered drugs, devices, and supplies. For a list of the most commonly prescribed drugs, please see the formulary.

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. Hemophilia Factors up to a plan maximum of five (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.
11. Plan B emergency contraceptive medications.
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 ninety (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. 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, except as specified under Covered Drugs.
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 under medical Covered Expenses/Services.
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 fifty (50) percent. 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 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	Plan Pays	Services
A: Basic	\$0	100%	Diagnostic and Preventive
B: Intermediate	\$75	80%	Minor Restorative, Endodontic, Periodontics, Prosthodontic, Oral Surgery
C: Major	\$75	75%	Major Restorative, Endodontic, Periodontics, Prosthodontic
D: Orthodontics	\$75	50%	Orthodontic; medically necessary

Plan Allowance: In-network/out-of-network is not applicable. The plan provides payment based on Usual & Customary Charges.

- Children under the age of six (6). The child's dental condition must be so complex that the dental procedure must be done under general anesthesia and must be done in a hospital or surgical daycare facility setting. A licensed dentist and the child's PCP must determine in advance that anesthesia and hospitalization are Medically Necessary due to the complexity of the child's dental condition.

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 during 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 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 the 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/mailing 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;
- 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 twelve (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(s) secondary. The DSGHP will be the primary health plan for students and will provide benefits as though no secondary plan(s) existed. The DSGHP may be the secondary plan for dependents, and benefits will be coordinated with any other eligible medical, surgical or hospital Plan(s) or coverage(s) so that combined payments under all programs will not exceed one hundred (100) percent of Allowable Expenses incurred for covered services and supplies. Coordination of benefits will be done in accordance with the State of New Hampshire insurance regulations and National Association of Insurance Commissioners (NAIC) guidelines.

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 Tricare or 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 of 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.

As of the date of publication of this Plan Document, the federal/state 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).
- Provisions of RSA 420-O Self-Funded Student Health Benefit Plans
- 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. In the event a case results in a decision by a court of law, the plan will adjudicate and subrogate the claim settlement in accordance with the court's final decision/ruling.
- 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 overpayment is recovered.

CLAIM PAYMENT/PROCEDURES

This section describes how we reimburse claims and what information is needed when you submit a claim.

Maximum Allowed Amount

General

This subsection describes how we determine the amount of reimbursement for Covered Services. Reimbursement for services rendered by In-Network and Out-of-Network Providers is based on the Plan's Maximum Allowed Amount for the Covered Service that you receive.

The Maximum Allowed Amount for the 2018-2019 DSGHP is the maximum amount of reimbursement DSGHP will allow for services and supplies:

- That meet DSGHP's definition of Covered Services, to the extent such services and supplies are covered under your Plan and are not excluded;
- That are Medically Necessary; and
- That are provided in accordance with all applicable pre-authorization, utilization management or other requirements set forth in this Document.

You will be required to pay a portion of the Maximum Allowed Amount to the extent you have not met your Deductible or have a Co-payment or Co-insurance.

When you receive Covered Services from an Out-of-Network Provider, you may be responsible for paying any difference between the Maximum Allowed Amount and the Provider's actual charges. This amount can be significant.

When you receive Covered Services from a Provider, DSGHP will, to the extent applicable, apply claim processing rules to the claim submitted for those Covered Services. These rules evaluate the claim information and, among other things, determine the accuracy and appropriateness of the procedure and diagnosis codes included in the claim. Applying these rules may affect DSGHP's determination of the Maximum Allowed Amount. DSGHP's application of these rules does not mean that the Covered Services you received were not Medically Necessary. It means DSGHP has determined that the claim was submitted inconsistent with procedure coding rules and/or reimbursement policies. For example, your Provider may have submitted the claim using several procedure codes when there is a single procedure code that includes all of the procedures that were performed. When this occurs, the Maximum Allowed Amount will be based on the single procedure code rather than a separate Maximum Allowed Amount for each billed code.

Likewise, when multiple procedures are performed on the same day by the same Doctor or another healthcare professional, DSGHP may reduce the Maximum Allowed Amounts for those secondary and subsequent procedures because reimbursement at 100% of the Maximum Allowed Amount for those procedures would represent duplicative payment for components of the primary procedure that may be considered incidental or inclusive.

Prompt Payment of New Hampshire Provider Post-Service Claims

In addition to the Post-Service Claim determination rules stated in "Timeframe for Post-Service Claim Determinations" (above), the following applies to claims for Covered Services furnished by a New Hampshire Provider: Claims will be paid according to the terms of New Hampshire law. Clean written claims will be paid within thirty (30) calendar days of receipt. Clean electronic claims will be paid within fifteen (15) calendar days of receipt. If the TPA fails to pay an initial claim within the timeframes, the TPA will pay the Provider or Member the eligible benefit for the claim plus an interest payment of one and one half (1.5) percent per month beginning from the date payment was due.

Payment of a claim is considered made on the date the check is issued or electronically transferred. The TPA will mail checks no later than five (5) business days after the date of issue.

A "clean claim" is a claim for payment of Covered Services rendered by a New Hampshire Provider and meeting the following requirements: The claim is submitted on the TPA's standard claim form using the most current published procedural codes, with all the required fields completed with correct and complete information in accordance with the Plan's published filing requirements.

"Electronic claims" means the transmission of data for the purpose of payment of claims for Covered Services furnished by a New Hampshire Provider, the claim being submitted in an electronic data format specified by the Plan.

If payment is denied or delayed, the TPA will notify the Provider or Subscriber within fifteen (15) calendar days of receipt. The notice will include the reason for denial or delay and an explanation of any additional information needed to complete processing. The TPA will adjudicate the claim within forty-five (45) calendar days of receipt of the additional information. If the notice of denial or delay is not made as required, the claim will be subject to the timeframes for clean claims stated above in this subsection.

Provider Network Status

The Maximum Allowed Amount may vary depending upon whether the Provider is an In-Network Provider or an Out-of-Network Provider. The DSGHP uses the Cigna Preferred Provider Organization (PPO) network.

An In-Network Provider is a Provider who is in the managed network for this specific health care plan or in a special Center of Excellence/or another closely managed specialty network, or who has a participation contract with our PPO Network. For Covered Services performed by an In-Network Provider, the Maximum Allowed Amount for this Plan is the rate the Provider has agreed with our PPO Network to accept as reimbursement for the Covered Services. Because In-Network Providers have agreed to accept the Maximum Allowed Amount as payment in full for those Covered Services, they should not send you a bill or collect for amounts above the Maximum Allowed Amount. However, you may receive a bill or be asked to pay all or a portion of the Maximum Allowed Amount to the extent you have not met your Deductible or have a Co-payment or Co-insurance. Please call Our TPA's HealthSmart's Customer Service at [1-844-206-0372] for help in finding a Network Provider or visit Cigna's PPO website at [<http://www.cigna.com>].

Providers who have not signed any contract with our PPO Network and are not in any of Cigna's networks are Out-of-Network. If you use an Out-of-Network Provider, your entire claim will be denied except for Emergency Care, or unless the services are approved by the Plan as an approved service.

For Covered Services You receive from an Out-of-Network Provider for Emergency Care or for services approved, the Maximum Allowed Amount for this Plan will be one of the following as determined by the Plan:

For Prescription Drugs, the Maximum Allowed Amount is the amount determined by DSGHP using prescription drug cost information provided by the Pharmacy Benefits Manager.

How to File a Claim Form for Medical Benefits

If services are furnished by an Out-of-Network Provider, you may need to submit your own claim form. Please contact DSGHP or HealthSmart, our Third-Party Claims Administrator (TPA), to obtain the correct claim form as prescribed by DSGHP for submission. 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. Please complete the claim form, include your itemized bill and any information about other insurance payment, and submit the claim to the address indicated on the claim form.

If you are not able to contact DSGHP, or HealthSmart to obtain a claim form, written notice of services rendered may be submitted to Cigna PPO without the claim form. The same information that would be given on the claim form must be included in the written notice of claim. This includes:

A separate claim form 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

<http://healthsmart.com/dartmouthcollege.aspx> (claim forms are also available at this website)

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.

Claims for services are to be submitted to the Plan for payment within ninety (90) days after services are received and payment is requested. In-network providers must submit a claim for payment within twelve (12) months of the date of service.

How to File a Claim for Prescription Drug Benefits

The Dartmouth Health Service Pharmacy and other HealthSmart Rx 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 HealthSmart Rx prescription drug claim form to:

HealthSmart Rx, Inc.
3320 West Market Street
Fairlawn, OH 44333

HealthSmart Rx prescription drug claim forms can be downloaded at <http://healthsmart.com/dartmouthcollege.aspx>

Questions concerning HealthSmart Rx coverage can be directed to HealthSmart at 844-206-0372 or at HealthSmart Rx Member services at 800-681-6912.

All claims for prescription drugs must be filed with the DSGHP within a twelve (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.

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 one hundred eighty (180) day period. Failure to appeal the Adverse Benefit Determination within the one hundred eighty (180) day period will render the determination final. Any appeal received after the one hundred eighty (180) day 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 sixty (60) day 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 healthcare 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 thirty (30) 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 one hundred eighty (180) day period. Failure to appeal the Adverse Benefit Determination within the one hundred eighty (180) day period will render the determination final. Any appeal received after the one hundred eighty (180) day 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, who is neither the original decision maker, the decision maker's subordinate nor the decision maker's supervisor 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 sixty (60) day 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, the decision maker's subordinate nor the decision maker's supervisor. 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 healthcare 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. A Covered Person may qualify for an expedited external review if either of the following conditions apply:

- The Plan agrees in writing to skip the first and/or second levels of benefit determination reviews as described above
- The Covered Person has not received a decision from the Claims Administrator in the required time frames as described above

External reviews are arranged through and overseen by the New Hampshire Insurance Department. They are conducted by neutral Independent Review Organizations (IRO) as certified by the Insurance Department. There is no cost to you for External Review. For complete information (including instructions on how to submit new information for review and time frames for completing an External Review), please refer to the websites below:

https://www.nh.gov/insurance/consumers/documents/ex_rev_guide.pdf
https://www.nh.gov/insurance/consumers/documents/ex_rev_app.pdf

To assert this right to independent external medical review, the Covered Person must request such review in writing within one hundred eighty (180) days after a decision is made upon the second level benefit determination above.

The IRO will issue a final decision within sixty (60) days of the receipt of the external review request.

The decision of the IRO will be final and binding on both the Plan and the Covered Person except to the extent that the Covered Person has other remedies under federal or state law.

Claim Appeal Processes

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

- Within sixty (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 sixty (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 sixty (60) days but in no case more than one hundred twenty (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 unintentional 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 subscriber/student wanted. The denial can be for many reasons.

For example:

1. The health plan simply doesn't cover the procedure;
2. The plan is notified that at the time the subscriber/student received the service, the subscriber/student 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 subscriber/student receives adverse benefit determinations from their health plans, subscriber/student can file an appeal. This *plan document* 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.

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 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 for each patient and child.

Chemical/Substance Abuse 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 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: Your share of the costs of a covered health care service, calculated as a percentage (for example, 20%) of the allowed amount for the service. You generally pay coinsurance plus any deductibles you owe. (For example, if the health insurance or plan's allowed amount for an office visit is \$100 and you've met your deductible, your coinsurance payment of 20% would be \$20. The health insurance or plan pays the rest of the allowed amount.)

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* 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 a 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 a spouse, child, or another 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 to 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 *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 postoperative 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 a 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, severe pain, that would lead a prudent layperson, possessing an average knowledge of medicine and health, to believe that his or her condition, sickness, or injury is of such a nature that not getting immediate medical care could result in; (a) placing the patient's health in serious danger or, for a pregnant women, placing the women's health or the health of her unborn child in serious danger; (b) serious impairment to bodily functions; or (c) serious dysfunction of any bodily organ or part. Such conditions include but are not limited to, chest pain, stroke, poisoning, including alcohol poisoning, serious breathing problems, unconsciousness, including as a result of drug or alcohol overdose, severe burns or cuts, uncontrolled bleeding, or seizures and such other acute conditions.

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

Medically Necessary (Medical Necessity): health care services or products provided to an enrollee for the purpose of preventing, stabilizing, diagnosing, or treating an illness, injury, or disease or the symptoms of an illness, injury, or disease in a manner that is:

- (a) Consistent with generally accepted standards of medical practice;
- (b) Clinically appropriate in terms of type, frequency, extent, site, and duration;
- (c) Demonstrated through scientific evidence to be effective in improving health outcomes;
- (d) A representative of "best practices" in the medical profession; and
- (e) Not primarily for the convenience of the enrollee or physician or other healthcare provider.

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.

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

Network Maximum Allowable Cost: The maximum amount that a pharmacy in the HealthSmart Rx 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.), Licensed Practical Nurse (L.P.N.) or Advance Practice Registered Nurse (A.P.R.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 most you pay during a Benefit Period for Covered Services before your Plan begins benefits. The Out-of-Pocket limit does not include your Premium, amounts over the Maximum Allowed Amount, or charges for health care that your Plan doesn't cover. The Out-of-Pocket Limit may consist of Deductibles, Coinsurance, and/or Copayments. Please see the "Benefit Chart" for details.

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 twenty-four (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 a result of a condition such as mental handicap, cerebral palsy, epilepsy or another neurological condition. This is 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 2018-2019 *Plan Year*.

Plan Sponsor: The Trustees of Dartmouth College

Plan Year: The twelve (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.), Pastoral Counselor, or Advance Practice Registered Nurse (A.P.R.N).

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 (8) hours in any twenty-four (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, operated according to the law, which provides: permanent and full-time facilities; 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 an *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 *Provider/Practitioner*. The authorization for *total disability* must be reauthorized the beginning of a new plan year if the twelve (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 *healthcare 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
Heather Earle, Ph.D., Director of Counseling & Human Development, Health Service
Dr. Ann Bracken, MD, Ph.D., PCPM Director, Health Service
David Leenders, Associate Director of Health Services & Director of Finance and Administration, Health Service
Tricia Spellman, Assistant VP for Finance
David Foster, Associate Director, Office of Risk and 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 Office Manager, Health Service
G. Dino Koff, Director of Financial Aid
Tawyna L. Grant, Manager, Dick Hall's House Pharmacy

~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

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-844-206-0372

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-844-206-0372

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-844-206-0372

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijjigo holne' 1-844-206-0372

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.



The State of New Hampshire Insurance Department

21 South Fruit Street, Suite 14; Concord, NH 03301
Tel.: (603) 271-2261 Fax: (603) 271-1406 TDD Access Relay NH: 1-800-735-2964

CONSUMER GUIDE TO EXTERNAL APPEAL

What is an External Appeal?

New Hampshire law gives individuals who are covered by fully-insured, health or dental insurance plans the right to have a nationally-accredited, independent, medical review organization (IRO), which is not affiliated with his/her insurance company, review and assess whether the company's denial of a specific claim or requested service or treatment is justified. This type of review is available when a recommended service or treatment is denied on the basis that it does not meet the insurer's requirements for medical necessity, appropriateness, health care setting, and level of care or effectiveness. This review is often called Independent External Appeal, **External Appeal**, External Health Review or simply External Review.

What are the eligibility requirements for External Appeal?

To be eligible for External Appeal the following conditions must be met:

- The patient must have a fully-insured health or dental insurance plan.
- The service that is the subject of the appeal request must be either a) a covered benefit under the terms of the insurance policy or b) a treatment that may be a covered benefit.
- Unless the patient meets the requirements for Expedited External Review (see below), the patient must have completed the Internal Appeal process provided by the insurer and have received a final, written decision from the insurer relative to its review.
 - Exception #1: The patient does not need to meet this requirement, if the insurer agrees in writing to allow the patient to skip its Internal Appeal process.
 - Exception #2: If the patient requested an internal appeal from the insurer, but has not received a decision from the insurer within the required time frame, the patient may apply for External Appeal without having received the insurer's final, written decision.
- The patient must submit the request for External Appeal to the Department within 180 days from the date appearing on the insurance company's letter, denying the requested treatment or service at the final level of the company's Internal Appeals process.
- The patient's request for External Appeal may not be submitted for the purpose of pursuing a claim or allegation of healthcare provider malpractice, professional negligence, or other professional fault.

What types of health insurance are excluded from External Appeal?

In general, External Appeal is available for most health insurance coverage. Service denials relating to the following types of insurance coverage or health benefit programs are not reviewable under New Hampshire’s External Appeal law:

- Medicaid (except for coverage provided under the NH Premium Assistance Program)
- The New Hampshire Children’s Health Insurance Program (CHIP)
- Medicare
- All other government-sponsored health insurance or health services programs.
- Health benefit plans that are self-funded by employers

Note: Some self-funded plans provide external appeal rights which are administered by the employer.

Can someone else represent me in my External Appeal?

Yes. A patient may designate an individual, including the treating health care provider, as his/her representative. To designate a representative, the patient must complete Section II of the External Review Application Form entitled “Appointment of Authorized Representative.”

Submitting the External Appeal:

To request an External Appeal, the patient or the designated representative must complete and submit the External Review Application Form, available on the Department’s website (www.nh.gov/insurance), and all supporting documentation to the New Hampshire Insurance Department. There is no cost to the patient for an External Appeal.

Please submit the following documentation:

- The completed External Review Application Form - signed and dated on page 6.
**** The Department cannot process this application without the required signature(s) **** A
- photocopy of the front and back of the patient’s insurance card or other evidence that the patient is insured by the insurance company named in the appeal.
- A copy of the insurance company’s letter, denying the requested treatment or service at the final level of the company’s internal appeals process.
- Any medical records, statements from the treating health care provider(s) or other information that you would like the review organization to consider in its review. If requesting an Expedited External
- Appeal, the Provider’s Certification Form.

If you have questions about the application process or the documentation listed above, please call the Insurance Department at 1-800-852-3416.

Mailing Address:

New Hampshire Insurance Department
Attn: External Review Unit
21 South Fruit Street, Suite 14
Concord, NH 03301

Expedited External Review Applications

- May be faxed to (603) 271-1406, or
- Sent by overnight carrier to the Department’s mailing address.

What is the Standard External Appeal Process and Time Frame for receiving a Decision? It may take up to 60 days for the Independent Review Organization (IRO) to issue a decision in a Standard External Appeal.

- Within 7 business days after receiving your application form, the Insurance Department (the Department) will complete a preliminary review of your application to determine whether your request is complete and whether the case is eligible for external review.
 - If the request is not complete, the Department will inform the applicant what information or documents are needed in order to process the application. The applicant will have 10 calendar days to supply the required information or documents.
- If the request for external appeal is accepted, the Department will select and assign an IRO to conduct the external review and will provide a written notice of the acceptance and assignment to the applicant and the insurer.
- Within 10 calendar days after assigning your case to an IRO, the insurer must provide the applicant and the IRO a copy of all information in its possession relevant to the appeal.
- If desired, the applicant may submit additional information to the IRO by the 20th calendar day after the date the case was assigned to the selected IRO. During this period, the applicant may also present oral testimony via telephone conference to the IRO. However, oral testimony will be permitted only in cases where the Insurance Commissioner determines that it would not be feasible or appropriate to present only written information.
 - To request a “teleconference,” complete Section VII of the application form entitled “Request for a Telephone Conference” or contact the Department no later than 10 days after receiving notice of the acceptance of the appeal.
- By the 40th calendar day after the date the case was assigned to the selected Independent Review Organization, the IRO shall a) review all of the information and documents received, b) render a decision upholding or reversing the determination of the insurer, and c) notify in writing the applicant and the insurer of the IRO’s review decision.

What is an Expedited External Appeal?

Whereas a Standard External Appeal may take 60 days, Expedited External Appeal is available for those persons who would be significantly harmed by having to wait. An applicant may request expedited review by checking the appropriate box on the External Review Application Form and by providing a Provider’s Certification Form, in which the treating provider attests that in his/her medical opinion adherence to the time frame for standard review would seriously jeopardize the patient’s life or health or would jeopardize the patient’s ability to regain maximum function. Expedited reviews must be completed in 72 hours.

If the applicant is pursuing an internal appeal with the insurer and anticipates requesting an Expedited External Appeal, please call the Department at 800-852-3416 to speak with a consumer services officer, so that accommodations may be made to receive and process the expedited request as quickly as possible.

Please note a patient has the right to request an Expedited External Appeal simultaneously with the insurer’s Expedited Internal Appeal.

What happens when the Independent Review Organization makes its decision?

- If the appeal was an Expedited External Appeal, in most cases the applicant and insurer will be notified of the IRO's decision immediately by telephone or fax. Written notification will follow.
- If the appeal was a Standard External Appeal, the applicant and insurer will be notified in writing.
- The IRO's decision is binding on the insurer and is enforceable by the Insurance Department. The decision is also binding on the patient except that it does not prevent the patient from pursuing other remedies through the courts under federal or state law.

Have a question or need assistance?

**Staff at the Insurance Department is available to help.
Call 800-852-3416 to speak with a consumer services officer.**



The State of New Hampshire Insurance Department
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Tel.: (603) 271-2261 Fax: (603) 271-1406 TDD Access Relay NH: 1-800-735-2964

INDEPENDENT EXTERNAL REVIEW

Appealing a Denied Medical or Dental Claim

New Hampshire law gives individuals who are covered by fully-insured, health or dental insurance plans the right to have a nationally-accredited, independent, medical review organization (IRO), which is not affiliated with his/her health insurance company, review and assess whether the company's denial of a specific claim or requested service or treatment is justified. These reviews are available when a recommended service or treatment is denied on the basis that it does not meet the insurer's requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness. This review is called Independent External Appeal, External Health Review or simply **External Review**.

There is no cost to the patient for an external review.

To be eligible for **Standard External Review**, the patient must (1) have a fully-insured health or dental insurance plan, (2) have completed the insurer's internal appeal process, and (3) have received a final denial of services from the insurer. A standard external review must be submitted to the Insurance Department within 180 days of the insurance company's final denial and may take up to 60 days for the IRO to make its decision.

To be eligible for **Expedited External Review**, the patient must (1) have a fully-insured health or dental insurance plan, and (2) the treating provider must certify that delaying treatment will seriously jeopardize the life or health of the patient or will jeopardize the patient's ability to regain maximum function. IROs must complete expedited reviews within 72 hours. An expedited external review may be requested and processed at the same time the patient pursues an expedited internal appeal directly with the insurance company.

For more information about external reviews, see the Insurance Department's [Consumer Guide to External Review](#), available at www.nh.gov/insurance, or call 800-852-3416 to speak with a Consumer Services Officer.

Have a question or need assistance?

**Staff at the Insurance Department is available to help.
Call 800-852-3416 to speak with a consumer services officer.**

SUBMITTING A REQUEST FOR EXTERNAL REVIEW

To request an external review, please provide the following documents to the New Hampshire Insurance Department at the address below:

- The enclosed, completed application form - signed and dated on page 6.
**** The Department cannot process this application without the required signature(s) ****
- A photocopy of the front and back of the patient's insurance card or other evidence that the patient is insured by the health or dental insurance company named in the appeal.
- A copy of the Health Insurance Company's letter, denying the requested treatment or service at the final level of the company's internal appeals process.
- Any medical records, statements from the treating health care provider(s) or other information that you would like the Independent Review Organization to consider in its review.
- If requesting an Expedited External Review, the treating Provider's Certification Form.

If you have questions about the application process or the documentation listed above, please call the Insurance Department at 1-800-852-3416.

Mailing Address:

New Hampshire Insurance Department Attn:
External Review Unit
21 South Fruit Street, Suite 14 Concord,
NH 03301

Expedited External Review applications may be faxed to (603) 271-1406 or sent by overnight carrier to the address above. If you wish to email the application package, please call the Insurance Department at 1-800-852-3416.



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EXTERNAL REVIEW APPLICATION FORM

Request for Independent External Appeal of a Denied Medical or Dental Claim

Section I – Applicant Information

Patient’s Name: _____ Patient’s Date of Birth: _____
 Applicant’s Name: _____ Applicant’s Email: _____ Applicant’s Mailing Address:
 _____ City: _____
 _____ State: _____ Zip Code: _____
 Applicant’s Phone Number(s): Daytime: (_____) _____ Evening: (_____) _____

Section II – Appointment of Authorized Representative

**** Complete this section, only if someone else is representing the patient in this appeal ****

You may represent yourself or you may ask another person, including your treating health care provider, to act as your personal representative. You may revoke this authorization at any time.

I hereby authorize _____ to pursue my appeal on my behalf.

Signature of Enrollee (or legal representative – Please specify relationship or title) **Date**

Representative’s Mailing Address: _____
 City: _____ State: _____ Zip Code: _____
 Representative’s Phone Number(s): Daytime: (_____) _____ Evening: (_____) _____

Section III - Insurance Plan Information

Member's Name: _____ Relationship to Patient: _____

Member's Insurance ID #: _____ Claim/Reference #: _____

Health Insurance Company's Name: _____

Insurance Company's Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Insurance Company's Phone Number: (_____) _____

Name of Insurance Company representative handling appeal: _____

Is the member's insurance plan provided by an employer? Yes _____ No _____

Name of employer: _____

Employer's Phone Number: (_____) _____

Is the employer's insurance plan self-funded? Yes* _____ No _____

*** If you are not certain, please check with your employer. Most self-funded plans are not eligible for external review. However, some self-funded plans may provide external review, but may have different procedures.**

New Hampshire Premium Assistance Program

Is the patient's health insurance provided through the Medicaid Premium Assistance Program, which is administered by the NH Department of Health and Human Services?

Yes _____ No _____

If yes, please provide the Medicaid ID number & complete the following records release:

Medicaid ID Number: _____

I, _____, hereby authorize the New Hampshire Insurance Department to release my external review file to the New Hampshire Department of Health and Human Services (DHHS), if I request a Medicaid Fair Hearing following my independent external review. I understand that DHHS will use this information to make a Fair Hearing determination and that the information will be held confidential.

Section IV – Information about the Patient’s Health Care Providers

Name of Primary Care Provider (PCP): _____ PCP’s Mailing Address:

City: _____ State: _____ Zip Code: _____

PCP’s Phone Number: () _____

Name of Treating Health Care Provider: _____

Provider’s clinical specialty: _____

Treating Provider’s Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Treating Provider’s Phone Number: () _____

Section V – Health Care Decision in Dispute

Describe the health insurer company’s decision in your own words. Include any information you have about the health care services, supplies or drugs being denied, including dates of service or treatment and names of health care providers. Explain why you disagree.

Please **attach** the following:



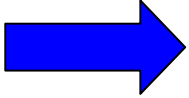
Additional pages, if
necessary; Pertinent
medical records;

If possible, a statement from the treating health care provider indicating why the

Continued

VIII – Authorization and Release of Medical Records

I, _____, hereby request an external review and authorize the patient's insurance company and the patient's health care providers to release all relevant medical or treatment records to the Independent Review Organization (IRO) and the New Hampshire Insurance Department. I understand that the IRO and the Department will use this information to make a determination to either reverse or uphold the insurer's denial. I also understand that the information will be kept confidential. I further understand that neither the Commissioner nor the IRO may authorize services in excess of those covered by the patient's health care plan. This release is valid for one year.



Signature of Enrollee (or legal representative – Please specify relationship or title)

Date

Before submitting this application, please verify that you have ...

- Completed all relevant sections of the External Review Application Form
- If appointing an authorized representative, the patient must complete Section II.
- If requesting an Expedited External Review, Section VI must be completed and the Provider Certification Form must be submitted.
- If requesting a telephone conference, Section VII must be completed.
- Signed and dated the External Review Application Form in Section VIII.
- Attached the following documents:
 - A photocopy of the front and back of the patient's insurance card or other evidence that the patient is insured by the health or dental insurance company named in the appeal.
 - A copy of the Health Insurance Company's letter, denying the requested treatment or service at the final level of the company's internal appeals process.
 - Any medical records, statements from the treating health care provider(s) or other information that you would like the Independent Review Organization to consider in its review.
 - If requesting an Expedited External Review, the treating Provider's Certification Form.



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PROVIDER'S CERTIFICATION FORM

For Expedited Consideration of a Patient's External Review

NOTE TO THE TREATING HEALTH CARE PROVIDER

The New Hampshire Insurance Department administers the external review process for all fully-insured health and dental plans in New Hampshire. A patient may submit an application for External Review, when his/her health or dental insurer has denied a health care service or treatment, including a prescription, on the basis that the requested treatment or service does not

meet the insurer's requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness.

The time frame for receiving a decision from an Independent Review Organization (IRO) for a Standard External Review is up to 60 days. Expedited External Review is available, ***only if*** the patient's treating health care provider certifies that, in his/her professional judgment, adherence to the time frame for standard review ***would seriously jeopardize the life or health of the covered person or would jeopardize the covered person's ability to regain maximum function.*** The time frame for receiving a decision from an IRO for an Expedited External Review is within 72 hours. An Expedited External Review may be requested and processed at the same time the patient pursues an Expedited Internal Appeal directly with the insurance company.

**** Expedited External Review is not available, when services have already been rendered ****

GENERAL INFORMATION

Name of Treating Health Care Provider: _____ Mailing

Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number: (_____) _____ Fax Number: (_____) _____

Email Address: _____

Licensure and Area of Clinical Specialty: _____

Name of Patient: _____

PROVIDER CERTIFICATION

I hereby certify that I am a treating health care provider for _____ (hereafter referred to as “the patient”); that adherence to the time frame for conducting a standard review of the patient’s external review would, in my professional judgment, seriously jeopardize the life or health of the patient or would jeopardize the patient’s ability to regain maximum function; and that for this reason, the patient’s appeal of the denial by the patient’s health insurer of requested medical services should be processed on an expedited basis.

I am aware that the Independent Review Organization (IRO) may need to contact me during non-business hours for medical information and that a decision will be made by the IRO within 72 hours of receiving this Expedited External Review request, regardless of whether or not I provide medical information to the IRO.

During non-business hours I may be reached at: (_____)

I certify that the above information is true and correct. I understand that I may be subject to professional disciplinary action for making false statements.

Treating Health Care Provider’s Name (Please Print)

Signature

Date