The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately.
This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, call 1-603-646-9438 or visit www.dartgo.org/studentinsurance. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms, see the Glossary. You can view the Glossary at https://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/affordable-care-act/for-employers-and-advisers/sbc-uniform-glossary-of-coverage-and-medical-terms-final.pdf or call 1-603-646-9438 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	PPO providers – $250 individual / $500 family Non-PPO providers – $500 individual / $1,000 family	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Deductible does not apply to Dartmouth College Health Service (Dick Hall's House), preventive care services, and non-biologically based outpatient mental health or substance abuse treatment.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	Yes. Prescription drug coverage: $50 individual / $100 family. There are no other specific deductibles.	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	PPO providers – $3,000 individual / $5,000 family Non-PPO providers - $6,000 individual / $10,000 family	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance billed charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out–of–pocket limit.
Will you pay less if you use a network provider?	Yes. See https://hcpdirectory.cigna.com/web/public/providers or call 1-844-206-0372 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	Yes.	This plan will pay some or all of the costs to see a specialist for covered services but only if you have a referral before you see the specialist.

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	20% coinsurance	30% coinsurance	----------none----------
	Specialist visit	20% coinsurance	30% coinsurance	----------none----------
	Preventive care/screening/ immunization	No charge	Not covered	Cost-sharing does not apply for preventive services. You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	30% coinsurance	The following titer tests are subject to applicable deductible and coinsurance: Hepatitis B Mumps Rubella (German Measles) Rubeola (Measles) Varicella-Zoster (Chicken Pox – Shingles)
	Imaging (CT/PET scans, MRIs)	20% coinsurance	30% coinsurance	----------none----------

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at: **www.dartgo.org/studentinsurance**	Generic drugs	$5 copay (30 day supply) or $10 copay (90 day supply) at Dick Hall's House Pharmacy, Dartmouth-Hitchcock Pharmacy & Dartmouth-Hitchcock Pharmacy @ Centerra. All other pharmacies: 20% coinsurance after prescription deductible	20% coinsurance after prescription deductible	Prescription drug deductible: **$50** individual / **$100** family Application of prescription copay: Copay applies per 30 day prescription. Dispensing limits: 90 day supply or 90 units, whichever is greater. No charge for preventive care prescription benefits including generic contraceptive medication and medically necessary brand name contraceptive medication.
	Preferred brand drugs	$15 copay (30 day supply) or $30 copay (90 day supply) at Dick Hall's House Pharmacy, Dartmouth-Hitchcock Pharmacy & Dartmouth-Hitchcock Pharmacy @ Centerra. All other pharmacies: 20% coinsurance after prescription deductible	20% coinsurance after prescription deductible	
	Non-preferred brand drugs	$15 copay (30 day supply) or $30 copay (90 day supply) at Dick Hall's House Pharmacy, Dartmouth-Hitchcock Pharmacy & Dartmouth-Hitchcock Pharmacy @ Centerra. All other pharmacies: 20% coinsurance after prescription deductible	20% coinsurance after prescription deductible	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Specialty drugs	$15 copay (30 day supply) or $30 copay (90 day supply) at Dick Hall's House Pharmacy, Dartmouth-Hitchcock Pharmacy & Dartmouth-Hitchcock Pharmacy @ Centerra All other pharmacies: 20% coinsurance after prescription deductible	20% coinsurance after prescription deductible	Dispensing limits: 90 day supply or 90 units, whichever is greater.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	30% coinsurance	----------none----------
	Physician/surgeon fees	20% coinsurance	30% coinsurance	----------none----------
If you need immediate medical attention	Emergency room care	$100 copay per visit	$100 copay per visit	Copay amount waived if admitted.
	Emergency medical transportation	$100 copay per trip	$100 copay per trip	----------none----------
	Urgent care	20% coinsurance	30% coinsurance	----------none----------
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	30% coinsurance	50% Prior Notification Penalty applies.
	Physician/surgeon fees	20% coinsurance	30% coinsurance	----------none----------

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	10% coinsurance; Deductible does not apply	20% coinsurance; Deductible does not apply	----------none----------
	Inpatient services	20% coinsurance	30% coinsurance	50% Prior Notification Penalty applies.
If you are pregnant	Office visits	20% coinsurance	30% coinsurance	Cost-sharing does not apply for preventive services.
	Childbirth/delivery professional services	20% coinsurance	30% coinsurance	----------none----------
	Childbirth/delivery facility services	20% coinsurance	30% coinsurance	50% Prior Notification Penalty applies.
If you need help recovering or have other special health needs	Home health care	20% coinsurance	30% coinsurance	50% Prior Notification Penalty applies.
	Rehabilitation services	20% coinsurance	30% coinsurance	----------none----------
	Habilitation services	20% coinsurance	30% coinsurance	----------none----------
	Skilled nursing care	20% coinsurance	30% coinsurance	Limited to 100 days per plan year; 50% Prior Notification Penalty applies.
	Durable medical equipment	20% coinsurance	30% coinsurance	----------none----------
	Hospice services	20% coinsurance	30% coinsurance	50% Prior Notification Penalty applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If your child needs dental or eye care	Children's eye exam	No charge	Not covered	The plan also covers Pediatric Vision Care for a child to age 19 – refer to the plan document.
	Children's glasses	$10 copay – for lenses, or $150 per plan year allowance for contact lenses; $150 per plan year allowance for frames	Not covered	
	Children's dental check-up	No charge	Not covered	The plan also covers Pediatric Dental Care for a child to age 19 – refer to the plan document.

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Cosmetic surgery
- Long-term care
- Routine eye care (Adult)
- Routine foot care
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Acupuncture
- Bariatric surgery (Covered only for medically necessary treatment of diseases and ailments caused by or resulting from obesity or morbid obesity; surgery to treat condition of obesity itself or morbid obesity itself is not covered.)
- Chiropractic care
- Dental care (Adult) (Limited to dental expenses incurred due to accidental injury to teeth.)
- Hearing aids (Benefits are available for one hearing aid per ear each time a hearing aid prescription changes.)
- Infertility treatment (Limited to diagnostic services to determine the cause of medically documented infertility.)
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing

Your Rights to Continue Coverage:

There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: State of New Hampshire Insurance Department at 1-603-271-2261 or http://www.nh.gov/insurance/index.htm, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov, or the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit https://www.HealthCare.gov or call 1-800-318-2596.

Extension of Eligibility – on termination of DSGHP eligibility, a covered person may elect to purchase the Extension of Eligibility for up to six (6) months under the new plan year. This Extension of Eligibility is designed to facilitate the transition to other insurance coverage. The application and payment for the cost of this coverage is due within thirty-one (31) days prior to the start of the plan year. For more information on your rights to continue coverage, contact the plan at 1-603-646-9438.

Your Grievance and Appeals Rights:

There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact the Dartmouth College Student Group Health Plan at 1-603-646-9438 or by email at Dartmouth.Student.Health.Plan@Dartmouth.edu.

Does this plan provide Minimum Essential Coverage? **Yes**

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet the Minimum Value Standards? **Yes**

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

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, kwiijigo holne' 1-844-206-0372.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	$250
Specialist coinsurance	20%
Hospital (facility) coinsurance	20%
Other coinsurance	20%

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,800**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$250
Copayments	$20
Coinsurance	$2,500
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	**$2,770**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$250
Specialist coinsurance	20%
Hospital (facility) coinsurance	20%
Other coinsurance	20%

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$250
Copayments	$400
Coinsurance	$1,400
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$2,050**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$250
Specialist coinsurance	20%
Hospital (facility) coinsurance	20%
Other coinsurance	20%

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$1,900**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$250
Copayments	$600
Coinsurance	$200
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,050**

The plan would be responsible for the other costs of these EXAMPLE covered services.