**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.healthcare.gov/sbc-glossary/ or call 1-800-318-2596 to request a copy.**

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| **What is the overall deductible?** | In-Network Provider: $100/Individual; $200/Family Out-of-Network Provider:$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. In-Network Preventive Care, Emergency Services, In-Network Prescription Drugs, Emergency Ambulance Services, Student Health Center/Infirmary are all services covered before you meet your deductible. | 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 Deductible: $100/Individual; $200/Family (In-Network and Out-of-Network Combined) | 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?** | In-Network Provider: $2,500/Individual; $5,000/Family Out-of-Network Provider: $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 Cigna Open Access Plus (OAP), or visit www.cigna.com or Wellfleetstudent.com or call Wellfleet at 833-443-5338 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?** | No. A referral is only required for Preventative Care Services in the Hanover, NH area. | This plan will pay some or all of the costs for covered services, but only cover the costs of Preventative Care Benefits in-network if you have a referral from Dartmouth College Health Service in the Hanover, NH area. |

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 | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| | | In-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 | 10% coinsurance after deductible | 30% coinsurance of Usual and Customary charges after deductible | ----------none---------- |
| | Specialist visit | 10% coinsurance after deductible | 30% coinsurance of Usual and Customary charges after deductible | ----------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) | 10% coinsurance after deductible | 30% coinsurance of Usual and Customary charges after deductible | The following titer tests are subject to applicable deductible and coinsurance:<br>Hepatitis B<br>Mumps<br>Rubella (German Measles)<br>Rubeola (Measles)<br>Varicella-Zoster (Chicken Pox – Shingles) |
| | Imaging (CT/PET scans, MRIs) | 10% coinsurance after deductible | 30% coinsurance of Usual and Customary charges after deductible | Pre-certification Requirement |

[* For more information about limitations and exceptions, see the plan or policy document at **www.dartgo.org/studentinsurance** or call 1-603-646-9438.]

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other |
|---|---|---|---|---|
| | | In-Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | Important Information |
| **If you need drugs to treat your illness or condition**<br>More information about **prescription drug coverage** is available at: **www.dartgo.org/studentinsurance** | Generic drugs (Tier One) | $10 copayment (1-30 day supply) or $20 copayment (31-90 day supply)<br><br>All other pharmacies: 20% coinsurance after prescription deductible | 20% coinsurance after prescription deductible | Prescription drug deductible: $100 individual / $200 family<br><br>Zero cost generics available.<br><br>Copayment is only applicable at Dick Hall's House Pharmacy, Dartmouth-Hitchcock Pharmacy, Dartmouth-Hitchcock Pharmacy @ Centerra & Cheshire Medical Center Pharmacy<br><br>Prescriptions at all other out-of-network pharmacies are subject to 20% coinsurance after prescription deductible<br><br>Dispensing limits: 90 day supply on non-specialty drugs and 30 day supply on specialty drugs unless the smallest package size exceeds these limits.<br><br>No charge for preventive care prescription benefits including generic contraceptive medication and medically necessary brand name contraceptive medication. |
| | Preferred brand drugs (Tier Two) | $20 copayment (1-30 day supply) or $40 copayment (31-90 day supply)<br><br>All other pharmacies: 20% coinsurance after prescription deductible | 20% coinsurance after prescription deductible | |
| | Non-preferred brand drugs (Tier Three) | $50 copayment (1-30 day supply) or $100 copayment (31-90 day supply)<br><br>All other pharmacies: 20% coinsurance after prescription deductible | 20% coinsurance after prescription deductible | |
| | Specialty drugs (Tier Three) | $50 copayment (per 30 day supply)$100 copayment (per 30 day supply)<br><br>All other pharmacies: 20% coinsurance after prescription deductible | 20% coinsurance after prescription deductible | |

[* For more information about limitations and exceptions, see the plan or policy document at **www.dartgo.org/studentinsurance** or call 1-603-646-9438.]

| Common Medical Event | Services You May Need | What You Will | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| | | In-Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | 10% coinsurance after deductible | 30% coinsurance of Usual and Customary charges after deductible | ----------none---------- |
| | Physician/surgeon fees | 10% coinsurance after deductible | 30% coinsurance of Usual and Customary charges after deductible | ----------none---------- |
| **If you need immediate medical attention** | Emergency room care | $100 copayment per visit | $100 copayment per visit | Copayment amount waived if admitted. |
| | Emergency medical transportation | Emergency Ground: $100 copayment per trip<br><br>Emergency Other: 10% coinsurance after deductible<br><br>Non-Emergency (prior approval required): 10% coinsurance after deductible | Emergency Ground: $100 copayment per<br><br>Emergency Other: 30% coinsurance of Usual and Customary charges after deductible<br><br>Non-Emergency (prior approval required): 30% coinsurance of Usual and Customary charges after deductible | Emergency Other: To the nearest Hospital where the needed medical care & treatment can be provided.<br><br>Non-Emergency prior approval required: Excludes Non-emergency fixed wing air ambulance from an out-of-network provider, except if prior approval has been received approval. |
| | Urgent care | 10% coinsurance after deductible | 30% coinsurance of Usual and Customary charges after deductible | ----------none---------- |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | 10% coinsurance after deductible | 30% coinsurance of Usual and Customary charges after deductible | Pre-Certification is required. 50% penalty for failing to follow requirement. |
| | Physician/surgeon fees | 10% coinsurance after deductible | 30% coinsurance of Usual and Customary charges after deductible | Pre-Certification is required. 50% penalty for failing to follow requirement. |

[* For more information about limitations and exceptions, see the plan or policy document at **www.dartgo.org/studentinsurance** or call 1-603-646-9438.]

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| | | In-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 of Usual and Customary charges; Deductible does not apply | ----------none---------- |
| | Inpatient services | 10% coinsurance after deductible | 30% coinsurance of Usual and Customary charges after deductible | Pre-Certification is required. 50% penalty for failing to follow requirement. |
| **If you are pregnant** | Office visits | 10% coinsurance after deductible | 30% coinsurance of Usual and Customary charges after deductible | Cost-sharing does not apply for preventive services. |
| | Childbirth/delivery professional services | 10% coinsurance after deductible | 30% coinsurance of Usual and Customary charges after deductible | Pre-certification after first 48 hours required 50% Penalty applies |
| | Childbirth/delivery facility services | 10% coinsurance after deductible | 30% coinsurance of Usual and Customary charges after deductible | Pre-certification after first 48 hours required 50% Penalty applies |
| **If you need help recovering or have other special health needs** | Home health care | 10% coinsurance after deductible | 30% coinsurance of Usual and Customary charges after deductible | Pre-certification required 50% Penalty applies |
| | Rehabilitation services | 10% coinsurance after deductible | 30% coinsurance of Usual and Customary charges after deductible | Inpatient Pre-certification required 50% Penalty applies |
| | Habitation services | 10% coinsurance after deductible | 30% coinsurance of Usual and Customary charges after deductible | ----------none---------- |
| | Skilled nursing care | 10% coinsurance after deductible | 30% coinsurance of Usual and Customary charges after deductible | Limited to 100 days per plan year; Pre-certification required 50% Penalty applies |
| | Durable medical equipment | 10% coinsurance after deductible | 30% coinsurance of Usual and Customary charges after deductible | Pre-certification Required over $500 |
| | Hospice services | 10% coinsurance after deductible | 30% coinsurance of Usual and Customary charges after deductible | Pre-certification required 50% Penalty applies |

[* For more information about limitations and exceptions, see the plan or policy document at **www.dartgo.org/studentinsurance** or call 1-603-646-9438.]

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| | | In-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 routine 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 copayment – for lenses, or $150 per plan year allowance for contact lenses; $150 per Hospice 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. |
| **If you need eye care** | Routine Eye exam | No charge | Not covered | This plan covers 1 eye exam every 12 months. |
| | Corrective lens hardware | $110 per plan year allowance | $110 per plan year allowance | No coverage after allowance. |

## 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
- 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 (No referral needed for first 12 visits.)
- 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

[* For more information about limitations and exceptions, see the plan or policy document at **www.dartgo.org/studentinsurance** or call 1-603-646-9438.]

## 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. For more information on your rights to continue coverage, contact the plan at 1-603-646-9438. 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.

## 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 833-443-5338.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 833-443-5338.
Chinese (中文): 如果需要中文的帮助， 请拨打这个号码 833-443-5338..
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 833-443-5338.

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

[* For more information about limitations and exceptions, see the plan or policy document at **www.dartgo.org/studentinsurance** or call 1-603-646-9438.]

## 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 | $100 |
| Specialist coinsurance | 10% |
| Hospital (facility) coinsurance | 10% |
| Other coinsurance | 10% |

**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 | $100 |
| Copayments | $0 |
| Coinsurance | $1,270 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Peg would pay is** | **$1,370** |

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

| | |
|---|---|
| The plan's overall deductible | $100 |
| Specialist coinsurance | 10% |
| Hospital (facility) coinsurance | 10% |
| Other coinsurance | 10% |

**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 | $100 |
| Copayments | $400 |
| Coinsurance | $690 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Joe would pay is** | **$1,190** |

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

| | |
|---|---|
| The plan's overall deductible | $100 |
| Specialist coinsurance | 10% |
| Hospital (facility) coinsurance | 10% |
| Other coinsurance | 10% |

**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 | $100 |
| Copayments | $100 |
| Coinsurance | $170 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | **$370** |

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