2026-2027

Dartmouth Student Group Health Plan (DSGHP)

Plan Document

Effective Date: September 1, 2026

Photo: Jeff Woodward

Mailing Address:
7 Rope Ferry Rd, HB# 6143
Hanover, NH 03755-1421

Email:
Dartmouth.Student.Health.Plan@Dartmouth.edu
Phone: (603) 646-9438
Fax: (603) 646-8893

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.

THIS PLAN IS UNDER THE JURISDICTION OF THE NEW HAMPSHIRE INSURANCE COMMISSIONER, PURSUANT TO RSA 400-A:15-C.

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

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

Dartmouth's Nondiscrimination policy may be found at https://students.dartmouth.edu/health-service/sites/students_health_service.prod/files/students_health_service/wysiwyg/dsghp_non_discrimination_notice.pdf

INTRODUCTION

Welcome to the Dartmouth Student Group Health Plan (DSGHP). Dartmouth 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, 2026.

Double Rainbow Over Dartmouth
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 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 as determined by Dartmouth Human Resources Office, students classified as Hybrid, students enrolled in non-credit courses (except international students), students enrolled in online programs 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

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

- Enrollee's spouse or domestic partner.
- Enrollee's child* younger than age twenty-six (26).
- Enrollee's 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 become 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 (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 your enrollment in DSGHP. 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 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 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.

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 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 Dartmouth. 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 Dartmouth College's waiver requirements, according to the conditions described in the Dartmouth College online waiver form. Your midyear waiver must be submitted by the fifteenth (15 th) 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 Dartmouth, 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, 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 Student Health Service for further information concerning the Extension of Eligibility.

CONTACT INFORMATION

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

The DSGHP Assistance Group

Campus - General Assistance

DSGHP Office

Mailing Address
7 Rope Ferry Road
Hinman Box 6143
Hanover NH 03755

Phone: 603-646-9438 or 603-646-9449

Fax: 603-646-8893

Web: dartgo.org/studentinsurance
Email: Dartmouth.Student.Health.Plan@Dartmouth.edu

Medical Claims Administrator/ Precertification of Hospital Admissions/Pediatric Dental

Wellfleet Student
PO Box 15369
Springfield, MA 01115-5369

Phone: 833-443-5338 (Toll Free)
413-452-5475 (Local)

Web: wellfleetstudent.com
Email: Customerservice@wellfleetinsurance.com

Plan Type/Network & Medical Claim Submission

Plan Type: PPO **Networking: Cigna OAP** **Open Access Plus, OA plus, Choice Fund OA Plus**

PO Box 188061
Chattanooga TN 37422-8062

Cigna OAP

Web: https://hcpdirectory.cigna.com/web/public/providers

Pharmacy Processor

Optum Rx
PO Box 650334
Dallas, TX 75265-0334

Phone: 800-334-8134

- **Anthem Dental Insurance**
-
- Website: http://www.anthem.com
- Phone: 844-729-1565

Dartmouth Travel Assistance Program

International SOS

Scholastic Members Phone: 215-942-8226

Web: https://www.internationalsos.com/MasterPortal/default.aspx?membnum=11BSGC000018 & https://www.dartmouth.edu/finance/financial-management/risk_insurance/rmstravel.php

Benefits for Services from Dartmouth Student Health Service

For services received at Dartmouth Student 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).

OAP Network Benefits

In-network providers are the physicians, hospitals, and other healthcare facilities that have contracted with Wellfleet/Cigna to provide specific medical services at negotiated prices. They are referred to collectively as the OAP Network. Providers in the OAP 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 OAP Network hospitals may be staffed with physicians and other professional staff who are not in the OAP Network. Unless otherwise specified, the charges of the Non-OAP Providers (out-of-network) will not be paid at the OAP Network level of benefits.

How to find an OAP Network Provider

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

1. See Cigna's OAP directory of in-network providers at:

   https://hcpdirectory.cigna.com/web/public/providers
2. Call Customer Service to ask for a list of doctors and providers that participate in the Cigna OAP network, based on specialty and geographic area. The toll-free Customer Service telephone number is 833-443-5338.
3. Check with your doctor or provider.

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

If you choose to use a provider that is not a member of the OAP 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 DSGHP Benefit Chart. Any amount applied toward the OAP Network Medical Deductible will be applied toward the Non-OAP Medical Deductible and vice versa.

Co-payments

The co-payment amounts, as specified in the DSGHP Benefit Chart, represent the dollar amounts required to be paid by the covered person for Covered Expenses/Services before the DSGHP pays benefits at the percentage described in the DSGHP Benefit Chart.

Co-insurance

Your share of the costs of a covered health care service, calculated as a percentage (for example, 10%) 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 10% would be $10. 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 DSGHP Benefit Chart 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 DSGHP Benefit Chart. 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 Precertification 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 OAP Network Out-of-pocket maximum will also be applied toward the Non-OAP 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 OAP and Non-OAP Network benefits combined.

2025-2026 DSGHP Benefit Chart (*Pre-Certification required)			
Deductibles & Out-of-Pocket Maximums		**In-Network**	**Combined In-Network and Out-of-Network**
Medical Deductible		$100 Individual $200 Family	$500 Individual $1,000 Family
Prescription Deductible (Does not apply to Dick Hall's House Pharmacy, Dartmouth-Hitchcock Pharmacy, Dartmouth-Hitchcock Pharmacy at Centerra and Cheshire Medical Center Pharmacy)		$100 Individual / $200 Family	
Medical and Prescription Out-of-Pocket Maximum		$2,500 Individual $5,000 Family	$6,000 Individual $10,000 Family (of usual and customary charges)
Benefit Description		**In-Network**	**Out-of-Network**
Preventive Care Services (If in Hanover, NH area: Services received at Dartmouth Student Health Service, or with a referral if services are not available at Dartmouth Student Health Service.)		No Charge	Not Covered
Services at Dartmouth Student Health Service (Except for certain medical equipment & supplies, and labs)		No Charge	N/A
Emergency Room Services (Co-payment waived if admitted.)		$100 co-payment	
Ambulance	Emergency Ground	$100 co-payment	
	Emergency Other (To the nearest hospital where the needed medical care & treatment can be provided.)	10% after Deductible	30% of Usual and Customary charges after deductible
	Non-Emergency (Prior approval required)	10% after Deductible	30% of Usual and Customary charges after deductible
Outpatient Mental / Nervous and Substance Abuse Treatment		10%; no Deductible	20% of Usual and Customary charges; no deductible
Outpatient Marital / Couples / Family / Bereavement Counseling			
Learning Disability Testing (100% coverage for first $1500)			
Outpatient Services for Physician Expenses		10% after Deductible	30% of Usual and Customary charges after deductible
*Inpatient Hospital Services and *Inpatient Mental/Nervous and Substance Abuse Treatment			
*Home Health Care Services			
*Skilled Nursing Facility (limited to 100 days)			
*Chiropractic Services		10% after Deductible	30% of Usual and Customary charges after deductible
*Gender Reassignment Surgery		10% after Deductible	30% of Usual and Customary charges after deductible
Early Intervention Services		10%, No Deductible	30% of Usual and Customary charges No deductible
Infertility/Fertility Care/Treatment		10% after Deductible	30% of Usual and Customary charges after deductible
Vision/Eyecare	Routine Vision/Eye Exam (One exam every twelve (12) months)	No Charge	Not Covered
	Corrective Lens Hardware Allowance of $110 (Ages 19 and Older)	Reimbursed up to $110 Allowance Only Per Plan Year	Reimbursed up to $110 Allowance Only Per Plan Year
Lifetime Individual Maximum for All Benefits (Unless otherwise specified.)		Unlimited	

Benefit Description	In-Network	Out-of-Network
National Collegiate Athletic Association (NCAA) Sanctioned Intercollegiate Sports Injuries (The DSGHP is primary for the first $90,000 of eligible expenses per injury, and secondary to coverage under the NCAA catastrophic policy for eligible expenses in excess of $90,000 per injury.)	Paid as any other in-network injury, Plan pays up to $90,000 of eligible expenses	Paid as any other out-of-network injury, Plan pays up to $90,000 of eligible expenses
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.)	Paid as any other in-network injury, Plan pays up to $30,000 of eligible expenses	Paid as any other out-of-network injury, Plan pays up to $30,000 of eligible expenses
Pharmacy Benefit Description	**In-Network**	**Out-of-Network**
Preferred Pharmacies Dick Hall's House Pharmacy, Dartmouth-Hitchcock Pharmacy, Dartmouth-Hitchcock Pharmacy at Centerra and Cheshire Medical Center Pharmacy (Not subject to prescription plan year deductible.)	Generic Drugs (Tier One) • $10 copayment per 30-day prescription • $20 copayment per 31–90-day prescription Preferred Brand Drugs (Tier Two) • $20 copayment per 30-day prescription • $40 copayment per 31–90-day prescription Non-preferred Brand Drugs (Tier Three) • $50 copayment per 30-day prescription • $100 copayment per 31–90-day prescription Specialty Drugs (Tier One & Two) • $50 copayment per 30-day prescription Specialty Drugs (Tier Three) • $100 copayment per 30-day prescription 100% coverage (not subject to the prescription plan year deductible) for generic contraception medication and medically necessary brand name and/or specialty contraception medication	
Other Pharmacies	80% Optum Rx participating pharmacies after deductible, 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 billed charges after deductible
Orally administered anti-cancer prescription drugs (including specialty drugs)*		
Benefit	**Greater of** • **Chemotherapy Benefit or** • **Infusion Therapy Benefit**	

Dispensing Limits: The amount of non-specialty drug which may be dispensed per prescription or refill (regardless of dosage form) is limited to a ninety (90) day supply. Specialty prescription drugs are limited to a thirty (30) day supply; however, you may receive up to a ninety (90) day supply if the drug is covered under the formulary without any utilization management requirements, you have taken the drug for a continuous period of one year, and the drug is not a controlled substance as defined by the USDEA. Other dispensing limits may be imposed as required by federal or state regulation for other reasons.
Under New Hampshire law, the following exception applies to retail and specialty drugs:

You may purchase up to a 90-day supply of covered Prescription Drugs at one time provided that:
- The Prescription Drug is on the health plan's formularylist
- You have taken the drug for a continuous period of one year, and
- The Prescription Drug is not subject to any utilization management requirements, including prior authorization and step therapy, under Your plan; and
- The Prescription Drug is not a controlled substance as defined by the USDEA.

You are responsible for the cost sharing applicable to the days' supply dispensed. You may purchase this supply of Prescription Drugs at a pharmacy of your choice as long as it is purchased at a network pharmacy.

A pharmacy may refuse to fill a Prescription order or refill when in the professional judgment of the pharmacist the prescription should not be filled.

Insulin Cost-Sharing Cap: Member cost-sharing capped at $30 per 30-day supply of insulin. Deductible is waived.
Orally administered anti-cancer medications cost-sharing cap: Member cost-sharing capped at $200 per prescription.
Dispense as Written (DAW): If a prescriber prescribes a covered Brand-Name Prescription Drug where a Generic Prescription Drug equivalent is available and specifies: "Dispense as Written" (DAW), the Member will pay the cost sharing for the Brand-Name Prescription Drug. If a prescriber does not specify DAW and the Member requests a covered Brand-Name Prescription Drug where a Generic Prescription Drug equivalent is available, the Member will be responsible for the cost difference between the Brand-Name Prescription Drug and the Generic Prescription Drug equivalent, and the cost sharing that applies to Brand-Name Prescription Drugs.

PPACA PREVENTIVE CARE BENEFITS

Preventative Care Benefits are provided by the DSGHP benefits in full compliance with the Patient Protection and Affordable Care Act (PPACA).

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

If DSGHP-covered person receives these services while in the Hanover, NH area, but not at the Dartmouth Student Health Service, a referral must be obtained from the Dartmouth Student Health Service for 100% coverage.

The DSGHP also provides certain preventative 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 Preventative Care Benefits are subject to change, pursuant to determinations by the U.S. Department of Health and Human Services and the U.S. Preventative Services Task Force. Refer to the websites for updates.

Covered Preventive Services for Adults

https://www.healthcare.gov/preventive-care-adults/

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

https://www.healthcare.gov/preventive-care-women/

Covered Preventive Services for Children

https://www.healthcare.gov/preventive-care-children/

General Requirements & Guidelines

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

1. A referral from Dartmouth Student Health Service is required for Preventative Care Services in the Hanover, NH area. If a referral is not obtained from the Dartmouth Student Health Service for such Preventative Care services, services will be processed at the out-of-network level, resulting in no coverage. This requirement does not apply to your dependent children.

2. You must notify the DSGHP, as described under the Health Care Management Program's Precertification of hospital admission requirement, of elective admissions to a hospital or skilled nursing facility and before receiving any home health care.

3. 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.

4. 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. OAP 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-OAP 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-OAP-Network Provider services.

5. 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.

Precertification 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, you must notify Wellfleet by calling their toll-free number (833-443-5338). 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. Precertification is not required for Emergency Room boarding for member patients waiting in an Emergency Department of an acute care hospital located in the state of New Hampshire while waiting for admission for psychiatric treatment to a facility located within the state.

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

For further details on Pre-certification process, refer to Pre-certification Process.

Pre-Certification Process

For treatment provided by an Out-of-Network Provider, failure to comply with the Pre-Certification process requirements may result in a Pre-Certification penalty. Such penalty amount is payable even though Deductible and Out-of-Pocket Maximum amounts have been met.

In-Network - Your In-Network Provider is responsible for obtaining any necessary Pre-certification before you receive the care. If Your In-Network Provider does not obtain the required Pre-Certification you will not be penalized. Please read below regarding review and notification.

Out-of-Network - You or Your Out-of-Network Provider are responsible for calling The Plan at the phone number found on the back of Your ID card and starting the Pre-Certification process. For Inpatient services the call must be made at least 5 working days prior to Hospital Confinement. For Outpatient services, the call must be made at least 5 working days prior to the start of the Outpatient service. In the case of an emergency, the call must take place as soon as reasonably possible.

The following Inpatient and Outpatient services or supplies require Pre-Certification:

1. All Inpatient admissions, including length of stay, to a Hospital, Skilled Nursing Facility, Rehabilitation or Residential Facility
2. All Inpatient maternity care after the initial 48/96 hours
3. High-risk maternity (routine only if inpatient exceeds federal requirements)
4. Residential Treatment facility (specific approval by Dartmouth Student Health Service is required)
5. Inpatient Mental Health and Substance Abuse hospital
6. Inpatient Mental Health and Substance Abuse residential
7. Inpatient Rehabilitation
8. Inpatient Detox
9. Acute Care and Long-term Acute Care
10. Gastric Bypass
11. Home Health Care
12. Durable Medical Equipment over $500
13. Outpatient Surgery*
14. Potential experimental/investigational procedures
15. Speech Therapy precertification required after the 12th visit by a Provider
16. Transplant Services
17. Cochlear implants
18. High Cost Diagnostic Testing (PET, MRI, CT)
19. Therapeutic radiology
20. Home infusion therapy*
21. Injectable medications*
22. Orthotics/prosthetics
23. Physical Therapy (Outpatient) precertification required after the 12th visit by a Provider
24. Occupational Therapy (Outpatient) precertification required after the 12th visit by a Provider
25. Chiropractic Services (Outpatient) precertification required after the 12th visit by a Provider
26. Unlisted Procedures

*Certain procedures require precertification, please contact Wellfleet for details.

Pre-Certification is not required for Emergency Medical Conditions or Urgent Care or Hospital Confinement for the initial 48/96 hours of maternity care.

Pre-Certification is not required for Emergency Room boarding for member patients waiting in an Emergency Department of an acute care hospital located in the state of New Hampshire while waiting for admission for psychiatric treatment to a facility located within the state.

Additionally, no authorization requirement will apply to obstetrical or gynecological care provided by In-Network Providers.

Pre-Certification is not a guarantee that Benefits will be paid.

Your Physician will be notified of the Plan's decision as follows:

1. For elective (non-emergency) admissions to a health care facility, the Plan will notify the Physician and the health care facility by telephone and/or in writing of the number of Inpatient days, if any, approved.
2. For Confinement in a health care facility longer than the originally approved number of days, the treating Physician or the health care facility must contact The Plan before the last approved day. The Plan will review the request for continued stay to determine Medical Necessity and notify the Physician or the health care facility of Our decision in writing or by telephone.
3. For any other covered services requiring Pre-Certification, the Plan will contact the Provider in writing or by telephone regarding our decision.

Our agent will make this determination within 72 hours for an urgent request and 4 business days for non-urgent requests following receipt of all necessary information for review. Notice of an Adverse Benefit Determination made by Our agent will be in writing and will include:

1. The reasons for the Adverse Benefit Determination include the clinical rationale, if any.
2. Instructions on how to initiate an appeal.
3. Notice of the availability, upon Your request or Your Authorized Representative, of the clinical review criteria relied upon to make the Adverse Benefit Determination. This notice will specify what, if any additional necessary information must be provided to, or obtained by, our agent in order to render a decision on any requested appeal.

Failure by Our agent to make a determination within the time periods prescribed shall be deemed to be an Adverse Benefit Determination subject to an appeal.

If You have any questions about Your Pre-Certification status, you should contact Your Provider.

Reduced Benefits for Failure to Follow Required Prior Pre-Certification Procedure for In-Patient Admissions only

If you do not follow the DSGHP's Pre-Admission Certification Requirement Pre-Certification 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 Precertification 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.

Medical Case Management is handled by the Cigna OAP network. Members are referred to Case Management during the pre-certification process. The program takes a personalized approach to understanding members' unique health care needs by supporting the process of seeking access to care and navigating through the health care system. Each case is assigned a case manager who provides proactive services throughout the life of the case based on the assigned intensity and in accordance with Cigna's Case Management policies.

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.

Medical Emergency Services

1. Ambulance Services
   Medically Necessary ambulance services are a Covered Service when one or more of the following criteria are met:
   a. You are transported by a state-licensed vehicle that is designed, equipped, and used only to transport the sick and injured and staffed by Emergency Medical Technicians (EMT), paramedics, or other certified medical professionals. This includes ground, water, fixed-wing, and rotary-wing air transportation.
   b. For ground ambulance, you are taken:
      - From your home, the scene of an accident or medical Emergency to a Hospital.
      - Between Hospitals, including when the Plan requires you to move from an Out-of-Network Hospital to an In-Network Hospital.
      - Between a Hospital and a Skilled Nursing Facility or other approved Facility.
   c. For air or water ambulance, you are taken:
      - From the scene of an accident or medical Emergency to a Hospital.
      - Between Hospitals, including when the Plan requires you to move from an Out-of-Network Hospital to an In-Network Hospital.
      - Between a Hospital and an approved Facility.

   Ambulance services are subject to Medical Necessity reviews by The Plan. When using an air ambulance, the Plan reserves the right to select the air ambulance Provider, except in a medical emergency. If you do not use the air ambulance Provider the Plan selects, except in a medical emergency, no benefits will be available. Out-of-Network Providers may bill you for any charges that exceed the Plan's Maximum Allowed Amount.

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

(*Pre-Certification required)

1. Amniocentesis.

2. *Computerized Axial Tomography (CAT Scan).

3. Diagnostic charges for laboratory services.

4. Blood testing for perfluoroalkyls (PFAS) and perfluorinated compounds (PFCS).

5. Diagnostic charges for X-rays.

6. Dual Energy X-ray Absorptiometry (DEXA Scan).

7. *Magnetic Resonance Imaging (MRI).

8. Mammography screening as specified under the Preventive Care Benefits.

9. Digital Tomosynthesis of the Breast
   Benefits will be provided for digital tomosynthesis to detect or screen for breast cancer. Benefits for digital tomosynthesis conducted to detect or screen for breast cancer in women 35 years of age and over are (1) not be subject to any Deductible, Copayment, or Coinsurance and (2) are subject to the limitations or any other provisions of this Plan Document. Benefits for digital tomosynthesis conducted for diagnostic purposes in women of any age shall be paid as any other Sickness and subject to all Deductible, Copayment, Coinsurance, limitations, or any other provisions of the Policy.

10. *Positron Emission Tomography (PET Scan).

11. Prostate-Specific Antigen (PSA) screening, payable as Preventive Care Services in the DSGHP Benefits Chart

12. Ultrasound.

Hospital Services
(*Pre-Certification required)

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. Emergency boarding for mental health as required by New Hampshire law.

7. 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
(*Pre-Certification required)

(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. Scalp Prosthesis

3. Blood and/or plasma and the equipment for its administration.

4. Breast Pump (limited to one pump per pregnancy, as specified under the Preventive Care Benefits.)

5. Compression therapy garments (e.g., Jobst garments).

6. *Durable medical equipment, including expenses related to necessary repairs and maintenance. (Pre-Certification is required for durable medical equipment over $500)

7. Enteral Formula and modified low protein food products. (Enteral pumps and related equipment and supplies)

8. 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.

9. Insulin infusion pumps.

10. 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.

11. *Orthotics, orthopedic or corrective shoes, and other supportive appliances for the feet. (Pre-Certification is required only for certain appliances/devices over $500.)

12. Oxygen and rental of equipment required for its use, not to exceed the purchase price of such equipment.

13. Sterile surgical supplies after surgery.

14. 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

(*Pre-Certification required)

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. (Pre-Certification required after the 13th visit by an In-Network Provider)

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. (Pre-Certification only required for certain procedures. Please contact Wellfleet.)

    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/Fertility Care Treatment Benefits – Coverage is provided for Medically Necessary expenses incurred for the diagnosis of Infertility; Fertility Treatment or Fertility Treatment that is otherwise Medically Necessary for a member but performed on another person for the benefit of the member; and for Standard Fertility Preservation Services. Benefits are payable on the same basis as any other Sickness.

    Covered Medical Expenses for Infertility include:

    - Evaluations,
    - Laboratory assessments,
    - Medications, and
    - Treatments associated with the procurement of donor eggs, sperm, and embryos.

    Coverage is provided for fertility preservation when a member is expected to undergo surgery, radiation, chemotherapy, or other medical treatment that is recognized by medical professionals to cause a risk of impairment of fertility. Coverage under this benef i t includes Standard Fertility Preservation Services, including the procurement and cryopreservation of embryos, eggs, sperm, and reproductive material determined not to be an Experimental Infertility Procedure. Storage shall be covered from the time of cryopreservation for the duration of the Policy Term.

    Limitations on coverage shall be based on clinical guidelines developed by the American Society for Reproductive Medicine, the American College of Obstetrics and Gynecology, or the Society for Assisted Reproductive Technology and the Insured Person's medical history.

    For the purpose of this section:
    Fertility Treatment means health care services or products provided with the intent to achieve a pregnancy that results in a live birth with healthy outcomes.
    Infertility means a disease, caused by an illness, injury, underlying disease, or condition, where an individual's ability to become pregnant or to carry a pregnancy to live birth is impaired, or where an individual's ability to cause pregnancy and live birth in the individual's partner is impaired. This includes both male and female infertility.
    Standard Fertility Preservation Services means procedures consistent with established medical practices and professional guidelines published by the American Society for Reproductive Medicine or the American Society of Clinical Oncology.
    Experimental Infertility Procedure means a procedure for which the published medical evidence regarding risks, benefits, and overall safety and efficacy is not sufficient to regard the procedure as an established medical practice.

    Infertility does not cover:

    - Procreative counseling;
    - Premarital examinations;
    - Genetic counseling and genetic testing;
    - Impotence, organic or otherwise;
    - Costs for an ovum donor or donor sperm;
    - Ovulation predictor kits;
    - Reversal of tubal ligations;
    - Reversal of vasectomies;
    - Costs for and relating to surrogate motherhood (maternity services are Covered for Members acting as surrogate mothers);
    - Cloning; or
    - Medical and surgical procedures that are experimental or investigational, unless the Plan's denial is overturned by an External Appeal Agent.

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 dysphoria.

15. *Inpatient/Outpatient Rehabilitation Services (Pre-Certification required for all inpatient, and/or after 12 outpatient visits):

    - Occupational therapy to restore a physical function or for habilitative therapy
    - Physical therapy from a qualified practitioner, for restorative or habilitative therapy
    - Speech therapy from a qualified practitioner to restore speech loss due to an illness, injury, or surgical procedure, or for habilitative 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 l earning disorder, are available within the Hanover NH Area only. 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. 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. 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 Student Health Services, Dartmouth 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 who are not billed by a home health care agency.

22. Non-surgical treatment of morbid obesity.

23. Non-surgical treatment for Temporomandibular Joint (TMJ) Disorders for Treatment provided for temporomandibular (joint connecting the lower jaw to the temporal bone at the side of the head) and craniomandibular (head and neck muscle) disorders.

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 change.

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). 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. Telemedicine

32. Termination of pregnancy - therapeutic or elective.

33. Titers when medically necessary, or for routine testing of the following only:

    - Hepatitis B
    - Mumps
    - Rubella (German Measles)
    - Rubeola (Measles)
    - Varicella-Zoster (Chicken Pox/Shingles)

34. Treatment of complications arising from any non-covered surgery or procedure.

35. Treatment of diabetes including diabetic education.

36. *Treatment of sleep disorders and sleep studies.

37. Treatment for long-term antibiotic therapy for tick-borne illness when determined to be medically necessary and ordered by a licensed infectious disease physician.

Mental/Nervous and Chemical/Substance Abuse Services

(*Pre-Certification required)

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.

10. Emergency boarding for mental health as required by New Hampshire law

11. Telemedicine

Specialized Treatment Facilities

(*Pre-Certification required)

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. (Pre-Certification required for inpatient only.)
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. (Pre-Certification required for inpatient only.)
9. *A substance abuse treatment facility. (Pre-Certification required for inpatient only.)
10. An ambulatory surgical facility.

Surgical Services

(*Pre-Certification required)

1. Anesthetic services, when performed by a licensed anesthesiologist or certified registered nurse anesthetist in connection with a surgical procedure.
   - This includes the administration of general anesthesia by a licensed anesthesiologist or anesthetist for dental procedures performed on a covered person who:
     - Children under the age of 13. 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 day care facility setting. A licensed dentist and the child's Physician must determine that anesthesia and hospitalization are Medically Necessary due to the complexity of the child's dental condition; or
     - Insured Persons who have exceptional medical circumstances or a Developmental Disability. The exceptional medical circumstance or the Developmental Disability must be one that places the Insured Person at serious risk unless the dental procedure is done under general anesthesia and must be done in a hospital or surgical day care facility setting.
2. Assistant surgeon's expenses.
3. Breast augmentation surgery (mammoplasty) and mastectomy, including hormone therapy, for the treatment of gender dysphoria. Coverage requires that a signed letter of support from a qualified mental health professional be sent to the DSGHP Claim Administrator. Contact the DSGHP office with any questions. Services considered to be cosmetic will not be covered (see Exclusions under Gender Reassignment) .

   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.
   - Each insurer that issues or renews any policy of group accident or health insurance providing benefits for medical or hospital expenses, shall provide to each group, or to the portion of each group comprised of certificate holders of such insurance who are residents of this state and who meet the criteria for testing as established by the Match Registry (the National Marrow Donor Program), coverage for laboratory fee expenses up to $150 arising from human leukocyte antigen testing, also referred to as histocompatibility locus antigen testing, for utilization in bone marrow transplantation. The testing shall be performed in a facility that is accredited by the American Association of Blood Banks or its successors, or the College of American Pathologists, or its successors, or any other national accrediting body with requirements that are substantially equivalent to or more stringent than those of the College of American Pathologists, and is licensed under the Clinical Laboratory Improvement Act of 1967, 42 U.S.C. section 263a, as amended. At the time of the new testing, the person tested shall complete and sign an informed consent form that also authorizes the results of the test to be used for participation in the National Marrow Donor Program and shall acknowledge a willingness to be a bone marrow donor if a suitable match is found.
   - In addition, the testing facility shall not bill, charge, collect a deposit from, seek payment or reimbursement from, or have recourse against a covered person or a person acting on behalf of the covered person for any portion of the laboratory fee expenses.

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 for Temporomandibular Joint (TMJ) Disorders for Treatment provided for temporomandibular (joint connecting the lower jaw to the temporal bone at the side of the head) and craniomandibular (head and neck muscle) disorders.

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

(*Pre-Certification required)

Requirements:

Gender reassignment surgery is considered a 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 gender reassignment therapy AND
- For hysterectomy, salpingo-oophorectomy, orchiectomy:
  - documentation of at least twelve (12) months of continuous hormonal gender reassignment therapy AND
  - recommendation for gender 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 gender reassignment therapy AND
  - recommendation for gender 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.

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
    - Metoidioplasy
    - 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
    - Calf implants
    - Nose implants
    - Collagen injections
    - Face/forehead lift
    - Insertion of testicular prosthesis
    - Laryngoplasty
    - Mastopexy
    - Neck tightening
    - 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
    - Voice modification surgery

Travel Outside of the United States

Dartmouth Travel Assistance Program

To assist Dartmouth travelers in coping with the risks of travel, Dartmouth has partnered with International SOS & Starr to provide medical and security assistance and international travel medical insurance when traveling internationally on Dartmouth-sponsored programs.

Information may be found at https://www.internationalsos.com/MasterPortal/default.aspx?membnum=11BSGC000018 & https://www.dartmouth.edu/finance/financial-management/risk_insurance/rmstravel.php

Important considerations or services associated with the program are:

- Eligible individuals are Dartmouth students, faculty, staff, college officials, volunteers, board members and Dartmouth-approved guests, under the age of 85, while traveling internationally (outside of their permanent country of residence) on Dartmouth-sponsored activities and dependents while traveling with a covered employee.
- Pre-trip information and consultation on travel health and security issues.
- Medical, dental, and counseling referrals.
- Emergency and routine medical advice.
- Sojourn travel: 14 days prior to a trip, during a trip, and after a Dartmouth-sponsored trip.
- Urgent and emergency international medical insurance.*
- Emergency dental insurance.*
- Outpatient mental health sessions.*
- Emergency security evacuation as deemed necessary by ISOS/Starr.
- Emergency medical evacuation and medically supervised repatriation, for eligible individuals as deemed necessary by ISOS/Starr.
- Routine medical insurance charges incurred by traveler are traveler's responsibility and will need to be submitted to traveler's health insurer for reimbursement.
- Dartmouth community members are eligible for discounted personal travel coverage by visiting ISOS membership or calling 1-800-523-8662.

  **Administered by International SOS.*

This summary of the Dartmouth Travel Assistance Program does not constitute a promise of benefits. Please contact Risk Management and Insurance or call 603-646-2442 for a complete description of ISOS &/or Starr's terms, conditions, limitations, and charges.

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 to request proof of coverage letter. Proof of coverage is also available 24/7, in your Wellfleet account.

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 Student 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. Educational, vocational, or training services and supplies, except as specifically provided by Dartmouth Student Health Services. This exclusion does not apply to the treatment of diabetes and Smoking Cessation.
11. Expenses exceeding the usual and customary charge for the geographic area in which services are rendered.
12. Expenses for broken appointments.
13. Expenses for preparing medical reports, itemized bills, or claim forms.
14. Expenses for prescription drugs or medicines. (See next section for Prescription Drug coverage.)
15. Expenses for services and supplies more than DSGHP limits or Benefit Maximums.
16. Expenses for supplies that do not require a Physician's prescription.
17. Expenses incurred for non-surgical treatment of the feet, including treatment of corns, calluses, and toenails, or other routine foot care, unless medically necessary.
18. 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.
19. Experimental/investigational equipment, services, or supplies.
20. 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 & DSGHP Benefits Chart.
21. Genetic counseling, except as specifically provided under Preventive Care Services.
22. Genetic testing, except as specifically provided under Preventive Care Services.
23. Hair removal, except as specifically provided under Gender Reassignment Surgery.
24. Hypnosis.
25. Mailing and/or shipping and handling expenses.
26. Massage therapy or Rolfing.
27. A non-emergency fixed-wing air ambulance from an out-of-network provider, except if prior approval has been received.

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 except 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. Gender change surgery, except as specifically provided under Covered Expenses/Services.

41. Gender 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. Titers for routine testing, except as specifically provided under Preventative Care Services and Covered Services/Expenses.

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. Al though 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.

Prescription Drugs are medications filled in an outpatient pharmacy for which a Physician's written prescription is required up to the amount shown in the DSGHP Benefit Chart. This benefit is limited to medication necessary for the Treatment of the Covered Injury or Covered Sickness for which a claim is made. Some outpatient prescription drugs are subject to pre-certification. These prescription requirements help Your prescriber and pharmacists check that Your outpatient prescription drug is clinically appropriate using evidence-based criteria.

This benefit offers at least one medication-assisted treatment therapy option approved by the federal Food and Drug Administration for treatment of substance use disorders without a requirement for prior authorization. The Plan will not require a renewal of a prior authorization for a medication- assisted treatment therapy for treatment of substance use disorders more frequently than once every 12 months.

The DSGHP utilizes Optum Rx for the administration of its Prescription Drug Benefits. Optum Rx has a nation-wide network of participating pharmacies. The Dick Hall's House Pharmacy is a member of the Optum Rx Pharmacy network.

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

Non- Optum 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:

https://www.optumrx.com

Step Therapy

Step Therapy: When medications for the Treatment of any medical condition are restricted for use by a step therapy or fail -first protocol, the prescribing practitioner shall have access to a clear and convenient process to request an override of the restriction from the Plan. An override of that restriction will be granted by the Plan upon completion of the review if all necessary information to perform the override review has been provided for the Step Therapy.

1. The prescribing practitioner can demonstrate, based on sound clinical evidence, that the preferred Treatment required under step therapy or fail-first protocol has been ineffective in the Treatment of the disease or medical condition; or
2. Based on sound clinical evidence or medical and scientificevidence:
    a. The prescribing practitioner can demonstrate that the preferred Treatment required under the step therapy or fail-first protocol is expected or likely to be ineffective based on the known relevant physical or mental characteristics of the Insured and known characteristics of the drug regimen; or
    b. The prescribing practitioner can demonstrate that the preferred Treatment required under the step therapy or fail-first protocol will cause or will likely cause an adverse reaction or other physicalharm.

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. Insulin (including insulin needles and diabetic supplies).
5. Legend Smoking Deterrents.
6. Legend Vitamin B12 (all dosage forms).
7. Necessary prescription medications and vaccines when required for international travel.
8. Oral fluoride products.
9. Oral, transdermal, intravaginal contraceptives, and contraceptive injections.
10. Plan B emergency contraceptive medications.
11. Prenatal vitamins.
12. Enteral Formula and modified low protein food products.
13. Self-Administered Prescription Drugs – Certain self-administered Prescription Drugs are only covered under the Prescription Drug benefit and are excluded from the medical benefit. Self-administered Prescription Drugs will not be covered when dispensed through a Physician's office or outpatient hospital, except in emergency situations. While members may self-administer these medications, they can still obtain these medications at the pharmacy and have them administered at an office visit. Coverage exceptions may be granted if self-administered Prescription Drugs are required as part of a hospitalization or emergency room visit. The list of self-administered Prescription Drugs only covered under the Prescription Drug benefit and excluded from the medical benefit can be found here: www.wellfleetstudent.com/providers.
14. Orally administered anti-cancer drugs, including chemotherapy drugs - Covered Medical Expenses include any drug prescribed for the treatment of cancer if it is recognized for treatment of that indication in a standard reference compendium or recommended in the medical literature even if the drug is not approved by the FDA for a particular indication.

Dispensing Limits

The amount of non-specialty drug which may be dispensed per prescription or refill (regardless of dosage form) is limited to a ninety (90) day supply. Specialty prescription drugs are limited to a thirty (30) day supply; however, you may receive up to a ninety (90) day supply if the drug is covered under the formulary without any utilization management requirements, you have taken the drug for a continuous period of one year, and the drug is not a controlled substance as defined by the USDEA. Other dispensing limits may be imposed as required by federal or state regulation or for other reasons. Some Outpatient Prescription Drugs are subject to quantity limits. The quantity limits help the prescriber and pharmacist check that the Outpatient Prescription Drug is used correctly and safely. The Plan relies on medical guidelines, FDA-approved recommendations and other criteria developed by the plan to set these quantity limits.

Insulin Cost-Sharing Cap: Member cost-sharing capped at $30 per 30-day supply of insulin
Orally administered anti-cancer medications cost-sharing cap: Member cost-sharing capped at $200 per prescription.

Under New Hampshire law, the following exception applies to retail and specialty drugs:

You may purchase up to a 90 day supply of covered Prescription Drugs at one time provided that:

- The Prescription Drug is on the health plan's formulary list

- You have taken the drug for a continuous period of one year, and
- The Prescription Drug is not subject to any utilization management requirements, including prior authorization and step therapy, under Your plan; and
- The Prescription Drug is not a controlled substance as defined by the USDEA.

You are responsible for the cost sharing applicable to the days supply dispensed. You may purchase this supply of Prescription Drugs at a pharmacy of Your choice as long as it is purchased at a network pharmacy.

A pharmacy may refuse to fill a Prescription order or refill when in the professional judgment of the pharmacist the prescription should not be filled.

Dispense as Written (DAW)

If a prescriber prescribes a covered Brand-Name Prescription Drug where a Generic Prescription Drug equivalent is available and specifies: "Dispense as Written" (DAW), the Member will pay the cost sharing for the Brand-Name Prescription Drug. If a prescriber does not specify DAW and the Member requests a covered Brand-Name Prescription Drug where a Generic Prescription Drug equivalent is available, the Member will be responsible for the cost difference between the Brand-Name Prescription Drug and the Generic Prescription Drug equivalent, and the cost sharing that applies to Brand-Name Prescription Drugs.

Exception Process

Formulary Exception Process – If a Prescription Drug is not on a Formulary, You, Your Authorized Representative or Your prescribing Physician may request a Formulary exception for clinically appropriate Prescription Drug in writing, electronically or telephonically. If coverage is denied under the standard or expedited Formulary exception process, the member is entitled to an external appeal as outlined in the External Appeal section of this document. Refer to the Formulary posted on website www. wellfleetstudent.com or call the number on the Member's ID card to find out more about this process.

Standard Review of a Formulary Exception – The Plan will make a decision and notify You or Your Authorized Representative and the prescribing Health Care Professional no later than 48 hours after receipt of the Member's request. If Plan approves the request, the Plan will cover the Prescription Drug while You are taking the Prescription Drug, including any refills. If the exception process exceeds 48 hours the prescription drug that required the exception will be covered.

Expedited Review of a Formulary Exception – If You are suffering from a health condition that may seriously jeopardize Your health, life or ability to regain maximum function or if You are undergoing a current course of Treatment using a Non-Formulary Prescription Drug, You may request an expedited review of a Formulary exception. The request should include a statement from Your prescribing Physician that harm could reasonably come to You if the requested drug is not provided within the timeframes for the Plan's standard Formulary exception process. The Plan will make a decision and notify You or Your Authorized Representative and the prescribing Physician no later than 24 hours after the Plan's receipt of Your request. If the Plan approves the request, the Plan will cover the Prescription Drug.

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 Student 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. GLP-1 drugs when used for weight loss or obesity management.

9. Impotency drugs.

10. Legend vitamins, except as specified under Covered Drugs.

11. Medication dispensed in excess of the dispensing limits.

12. 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.

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.

DENTAL

Anthem Dental Insurance

As part of your membership in the DSGHP, you are automatically enrolled in dental insurance provided by Anthem. It is important to know that Anthem Dental Insurance is a separate policy from the DSGHP. For additional information on coverage and benefits please visit https://students.dartmouth.edu/health-service/fees-insurance/insurance/dental-insurance.

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. Dental insurance benefits are provided through the Anthem Dental Insurance as indicated above.

Pediatric Dental Benefits

(Coverage for ages 0-18)

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 w hether 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;
- 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;
- 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
(Coverage for ages 0-18)

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 Pla n(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.

https://students.dartmouth.edu/health-service/about/about-dartmouths-health-service/confidentiality

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. The patient shall not be denied appropriate care on the basis of race, religion, color, national origin, sex, gender identity, age, disability, marital status, or source of payment, nor shall any such care be denied on account of the patient's sexual orientation. RSA 151:21 XVI

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 Student 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 orinjury.

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 othercoverage.
- Agree to hold the proceeds of any recovery received in trust for theDSGHP.
- 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 Plan Year 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 with in fifteen (15) calendar days of receipt. If the Third-Party Claims Administrator (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 Open Access Plus (OAP) 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 the Plan's OAP 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 the Plan's OAP 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 the Plan's TPA Wellfleet's Customer Service at 1-833-443-5388 for help in finding a Network Provider or visit Cigna's OAP website at https://hcpdirectory.cigna.com/web/public/consumer/directory/search?consumerCode=HDC001.

Providers who have not signed any contract with the Plan's OAP 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:

- Emergency Room Services (co-payment waived if admitted.) the plan will pay 100% after $100 co-payment
- Ambulance
    - Emergency Ground 100% after $100 co-payment
    - Emergency Other (To the nearest hospital where the needed medical care & treatment can be provided.) and Non-Emergency (prior approval required) the plan will pay 70% of Usual and Customary charges after the deductible.

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 Wellfleet, the Plan's TPA, to obtain the correct claim form as prescribed by DSGHP for submission. Medical claim forms may be 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 Wellfleet to obtain a claim form, written notice of services rendered may be submitted to Cigna OAP 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.

- 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 OAP
PO Box 188061
Chattanooga, TN 37422-8061

If you have any questions regarding a claim, please call Wellfleet at 833-443-5338, Monday through Thursday, 8:30 a.m. to 7:00 p.m., Friday, 8:30 a.m. to 5:00 p.m., Eastern Time.

In-network providers must submit a claim for payment within twelve (12) months of the date of service.

Out-of-netowrk claims for services are to be submitted to the Plan for payment within ninety (90) days after services are received and payment is requested.

How to File a Claim for Prescription Drug Benefits

The Dartmouth Health Service Pharmacy and other Optum Rx pharmacies will submit your claim for you if you show you rOptum Rx 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 Optum Rx prescription drug reimbursement form to:

Optum Rx
PO Box 650334
Dallas, TX 75265-0334

Optum Rx prescription drug reimbursement forms can be downloaded at:
https://www.optumrx.com/content/dam/optumrx-o5/forms/Claim-Form-UHG-Medicare-PDP-MAPD-Commercial-PPO-Union-and-Others.pdf

Questions concerning Optum Rx coverage can be directed to RxBenefits at 800-334-8134. 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

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 internal and external reviews and the Covered Person must exercise both levels of review before bringing a civil action.

To initiate the internal level of benefits 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 following receipt of notification of an Adverse Benefit Determination denial. 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).

The internal 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 internal level of review will be sent to the Covered Person within thirty (30) days following the date the Claims Administrator receives the appeal 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 may initiate an independent external review. Please see section below titled "Independent External Review"

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:

Wellfleet Insurance Company
Appeals
PO Box 15369
Springfield, MA 01115

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

Expedited Review for Immediate or Urgently-Needed Services

In place of the internal formal review as described above in this section, you have the right to request an "expedited" review right away when your situation is for immediate or urgently-needed services and waiting for a response under the review time frames described above would seriously jeopardize your life or health or your ability to regain maximum function as determined by the Claims Administrator or your physician, or if your physician says that you will have severe pain that cannot be adequately managed without the care or treatment that is the subject of the review. The expedited review can be an internal expedited review, or you can request an expedited internal and expedited external review simultaneously.

If you request an expedited internal review, the Claims Administrator will review your request and notify you of the decision within seventy-two (72) hours after your request is received, or such shorter time period as required by federal law. If you request an expedited external review, the NH Insurance Department will review your request and notify you of the decision within seventy-two (72) hours after your request is received, or such shorter time period as required by federal law.

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:

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 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 internal level of benefits review, the Covered Person must submit in writing an appeal or a request for revie w of the Adverse Benefit Determination to the Plan within one hundred eighty (180) days following receipt of a notification of an 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).

The internal 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 internal 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.

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:

Wellfleet Insurance Company
Appeals
PO Box 15369
Springfield, MA 01115

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

Independent External Review

A Covered Person may also request an independent external review of any Adverse Benefit Determination involving a question of Medical Necessity, or other issues requiring medical expertise for resolution. A Covered Person may qualify for an expedited external review if either of the following conditions applies:

- The Plan agrees in writing to skip the internal review of benefit determination 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 an 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.insurance.nh.gov/consumers/health-insurance/healthcare-and-long-term-care-appeals.

To assert this right to an independent external medical review, the Covered Person must request such review in writing within one hundred eighty (180) days after receipt of an Adverse Benefit Determination

The IRO will issue a final decision within forty-five (45) days of the receipt of the external review request, or as expeditiously as the medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request for an expedited external review. If the notice is not in writing within 48 hours after the date of providing that notice, the assigned IRO must provide written confirmation of the decision to the claimant and the plan or issuer

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.

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."
   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.

Brand-Name Prescription Drug: A Prescription Drug whose manufacture and sale is controlled by a single company as a result of a patent or similar right. Refer to the Formulary for the tier status.

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 professio nal 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 w ithout the training of a *health care provider.*

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

DSGHP Administrator: Dartmouth 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 Wellfleet as the Plan's Third-Party Claims Administrator (TPA) to perform claims processing and other specified services in relation to the DSGHP. Wellfleet 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.

Dispense as Written (DAW): A term prescribers use to indicate that a Brand-Name prescription drug should be dispensed rather than the Generic Prescription Drug equivalent.

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.

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 rev iew 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 orprocedure.

6. Whether other, more conventional methods of treatment have beenexhausted.

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*.

Generic Prescription Drug: Any Prescription Drug that is not a Brand-Name Prescription Drug. Refer to the Formulary for the tier status.

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 for Dartmouth 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 acuteconditions.

Medical Withdrawal: The policies for medical withdrawal are formally established and published by Dartmouth. 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 healthoutcomes;
(d) A representative of "best practices" in the medical profession; and
(e) Not primarily for the convenience of the enrollee or physician or other healthcareprovider.

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 Optum RX 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 Access Plus (OAP*) (In-Network Providers)**: *Open Access Plus* or OAP means the *physicians*, *hospitals,* and other *practitioners* who have contracted with the DSGHP to provide specific medical care services at negotiated prices

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 for periods other than September 1 throughSeptember 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 med ical 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 Hospitalizatio*n**: 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 2022-2023 *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).

Prior Authorization: A coverage review to ensure medical necessity, appropriateness, and safety of a treatment or service.

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.

Self-Administered Prescription Drugs: medications that can be used on an outpatient bases and generally do not require clinical supervision or assistance to consume, apply, or inject.

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.

Specialty Drug: A type of prescription drug that, in general, requires special handling or ongoing monitoring and assessment by a health care professional, or is relatively difficult to dispense. Generally, *specialty drugs* are the most expensive drugs on a formulary.

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*.

Step Therapy: A limitation that requires the use of specific medications prior to the coverage of another medication.

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.

Telemedicine*:* The practice of health care delivery, diagnosis, consultation, treatment, transfer of medical data, and education using interactive audio, video, or data communications involving a real time (synchronous) or near real time (asynchronous) two-way transfer of medical data and information or audio only. Neither a telephone conversation nor an electronic messaging between a *Physician* and You constitutes *Telemedicine*.

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 schoolwork. 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
Jake Kransteuber, Manager, Decision Support and Financial Consulting
Kathleen Viveiros, Director, Risk Management and Insurance
Gary Hutchins, Asst. Dean of Graduate and Advanced Studies
Christian L Potter, Senior Immigration Advisor to International Students & Scholars, OVIS
G. Dino Koff, Director of Financial Aid
Heather Earle, Ph.D., Director of Counseling & Human Development, Health Service
Dr. Ann Bracken, MD, Ph.D., PCPM Director, Health Service
Chanel M Ramsey, Director of Finance and Administration, Health Service
Diana Kiefer, Assistant Director of Finance, Health Service
Michelle L Murray, SHP Operations & Eligibility Specialist, Health Service
Tracy Wallace, SHP Specialist, Health Service
Kerry J Horan, Pharmacy Supervisor, Dick Hall's House Pharmacy
Tina Levengood, Risk Management and Insurance

Healthcare Management & Benefit Consultants

Gallagher Student Health and Special Risk

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

Dartmouth Student 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 Student 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 1-833-443-5338

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-833-443-5338
Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-833-443-5338
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-833-443-5338

Michelle Murray
SHP Operations & Eligibility Specialist

Michelle joined the DSGHP staff the summer of 2010.

Tracy Wallace
SHP Specialist

Tracy joined the DSGHP staff the spring of 2015.

ImportantDisclosureInformation New Hampshire Addendum

Certain state laws require the disclosure of additional information. Described below is additional information applicable New Hampshire residents enrolled in the plan:

Patients' Bill of Rights

The policy describing the rights and responsibilities of each patient admitted to the facility shall include, as a minimum, the following:

I. The patient shall be treated with consideration, respect, and full recognition of the patient's dignity and individuality, including privacy in treatment and personal care and including being informed of the name, licensure status, and staff position of all those with whom the patient has contact, pursuant to **RSA 151:3-b**.

II. The patient shall be fully informed of a patient's rights and responsibilities and of all procedures governing patient conduct and responsibilities. This information must be provided orally and in writing before or at admission, except for emergency admissions. Receipt of the information must be acknowledged by the patient in writing. When a patient lacks the capacity to make informed judgments the signing must be by the person legally responsible for the patient.

III. The patient shall be fully informed in writing in language that the patient can understand, before or at the time of admission and as necessary during the patient's stay, of the facility's basic per diem rate and of those services included and not included in the basic per diem rate. A statement of services that are not normally covered by Medicare or Medicaid shall also be included in this disclosure.

IV. The patient shall be fully informed by a health care provider of his or her medical condition, health care needs, and diagnostic test results, including the manner by which such results will be provided and the expected time interval between testing and receiving results, unless medically inadvisable and so documented in the medical record, and shall be given the opportunity to participate in the planning of his or her total care and medical treatment, to refuse treatment, and to be involved in experimental research upon the patient's written consent only. For the purposes of this paragraph "health care provider" means any person, corporation, facility, or institution either licensed by this state or otherwise lawfully providinghealth care services, including, but not limited to, a physician, hospital or other health care facility, dentist, nurse, optometrist, podiatrist, physical therapist, or psychologist, and any officer, employee, or agent of such provider acting in the course and scope of employment or agency related to or supportive of health careservices.

V. The patient shall be transferred or discharged after appropriate discharge planning only for medical reasons, for the patient's welfare or that of other patients, if the facility ceases to operate, or for nonpayment for the patient's stay, except as prohibited by Title XVIII or XIX of the Social Security Act. No patient shall be involuntarily discharged from a facility because the patient becomes eligible for Medicaid as a source ofpayment.

VI. The patient shall be encouraged and assisted throughout the patient'sstay to exercise the patient's rights as a patient and citizen. The patient may voice grievances and recommend changes in policies and services to facility staff or outside representatives free from restraint, interference, coercion, discrimination, or reprisal.

VII. The patient shall be permitted to manage the patient's personal financial affairs. If the patient authorizes the facility in writing to assist in this management and the facility so consents, the assistance shall be carried out in accordance with the patient's rights under this subdivision and in conformance with state law and rules.

VIII. The patient shall be free from emotional, psychological, sexual and physical abuse and from exploitation, neglect, corporal punishment and involuntary seclusion.

IX. The patient shall be free from chemical and physical restraints except when they are authorized in writing by a physician for a specific and limited time necessary to protect the patient or others from injury. In an emergency, restraints may be authorized by the designated professional staff member in order to protect the patient or others from injury. The staff member must promptly report such action to the physician and document same in the medical records.

X. The patient shall be ensured confidential treatment of all information contained in the patient's personal and clinical record, including that stored in an automatic data bank, and the patient's written consent shall be required for the release of information to anyone not otherwise authorized by law to receive it. Medical information contained in the medical records at any facility licensed under this chapter shall be deemed to be the property of the patient. The patient shall be entitled to a copy of such records upon request. The charge for the copying of a patient's medical records shall not exceed $15 for the first 30 pages or $.50 per page, whichever is greater; provided that copies of filmed records such as radiograms, x-rays, and sonograms shall be copied at a reasonable cost.

XI. The patient shall not be required to perform services for the facility. Where appropriate for therapeutic or diversional purposes and agreed to by the patient, such services may be included in a plan of careand treatment.

XII. The patient shall be free to communicate with, associatewith, and meet privately with anyone, including family and resident groups, unless to do so would infringe upon the rights of other patients. The patient may send and receive unopened personal mail. The patient has the right to have regular access to the unmonitored use of a telephone.

XIII. The patient shall be free to participate in activities of any social, religious, and community groups, unless to do so would infringe upon the rights of other patients.

XIV. The patient shall be free to retain and use personal clothing and possessions as space permits, provided it does not infringe on the rights of other patients.

XV. The patient shall be entitled to privacy for visits and, if married, to share a room with his or her spouse if both are patients in the same facility and where both patients consent, unless it is medically contraindicated and so documented by a physician. The patient has the right to reside and receive services in the facility with reasonable accommodation of individual needs and preferences, including choice of room and roommate, except when the health and safety of the individual or other patients would be endangered.

XVI. The patient shall not be denied appropriate careon the basis of race, religion, color, national origin, sex, gender identity, age, disability, marital status, familial status, or source of payment, source of income, or profession nor shall any such care be denied on account of the patient's sexual orientation.

XVII. The patient shall be entitled to be treated by the patient's physician of choice, subject to reasonable rules and regulations of the facility regarding the facility's credentialing process.

XVIII. The patient shall be entitled to have the patient's parents, if a minor, or spouse, or next of kin, unmarried partner, or a personal representative chosen by the patient, if an adult, visit the facility, without restriction, if the patient is considered terminally ill by the physician responsible for the patient'scare.

XIX. The patient shall be entitled to receive representatives of approved organizations as provided in **RSA151:28**.

XX. The patient shall not be denied admission tothe facility based on Medicaid as a source of payment when there is an available space in the facility.

XXI. Subject to the terms and conditions of the patient's insurance plan, the patient shall have access to any provider in his or her insurance plan network and referral to a provider or facility within such network shall not be unreasonably withheld pursuant to **RSA420-J:8,XIV**.

XXII. The patient shall not be denied admission, care, or services based solely on the patient's vaccination status.

XXIII.

(a) In addition to the rights specified in paragraph XVIII, the patient shall be entitled to designate a spouse, family member, or caregiver who may visit the facility while the patient is receiving care. A patient who is a minor may have a parent, guardian, or person standing in loco parentis visit the facility while the minor patient is receiving care.

(b)

(1) Notwithstanding subparagraph (a), a health care facility may establish visitation policies that limit or restrict visitation when:

(A) The presence of visitors would be medically or therapeutically contraindicated in the best clinical judgment of health care professionals;

(B) The presence of visitors would interfere with the care of or rights of any patient;

(C) Visitors are engaging in disruptive, threatening, or violent behavior toward any staff member, patient, or another visitor; or

(D) Visitors are noncompliant with written hospital policy.

(2) Upon request, the patient or patient's representative, if the patient is incapacitated, shall be provided the reason for denial or revocation of visitation rights under this paragraph.

(c) A health care facility may require visitors to wear personal protective equipment provided by the facility, or provided by the visitor and approved by the facility. A health care facility may require visitors to comply with reasonable safety protocols and rules of conduct. The health care facility may revoke visitation rights for failure to comply with this subparagraph.

(d) Nothing in this paragraph shall be construed to require a health care facility to allow a visitor to enter an operating room, isolation room, isolation unit, behavioral health setting or other typically restricted area or to remain present during the administration of emergency care in critical situations. Nothing in this paragraph shall be construed to require a health care facility to allow a visitor access beyond the rooms, units, or wards in which the patient is receiving care or beyond general common areas in the health care facility.

(e) The rights specified in this paragraph shall not be terminated, suspended, or waived by the health care facility, the department of health and human services, or any governmental entity, notwithstanding declarations of emergency declared by the governor or the legislature. No health care facility licensed pursuant to RSA 151:2 shall require a patient to waive the rights specified in this paragraph.

(f) Each health care facility licensed pursuant to RSA 151:2 shall post on its website:

(1) Informational materials explaining the rights specified in this paragraph;

(2) The patients' bill of rights which applies to the facility on its website; and

(3) Hospital visitation policy detailing the rights and responsibilities specified in this paragraph, and the limitations placed upon those rights by written hospital policy on its website.

(g) Unless expressly required by federal law or regulation, the department or any other state agency shall not take any action arising out of this paragraph against a health care facility for:

(1) Giving a visitor individual access to a property or location controlled by the health care facility;

(2) Failing to protect or otherwise ensure the safety or comfort of a visitor given access to a property or location controlled by the health care facility;

(3) The acts or omissions of any visitor who is given access to a property or location controlled by the health care facility.

N.H. Rev. Stat. § 151:21

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, thepatient 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 theinsurer.
- 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 theappeal.
- 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 formentitled "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
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

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.

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

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 relationshipor 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 disputed service, supply, or drug is medically necessary.

_____

_____

_____

_____

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_____

Continued on next page

Section VI – Expedited Review

**** Complete this section, only if you would like to request expedited review ****

The patient may request that the external review be handled on an expedited basis. To request expedited review, the treating health care provider must complete the attached Provider Certification Form, certifying that a delay would seriously jeopardize the life or health of the patient or would jeopardize the patient's ability to regain maximum function.

Do you request an expedited review? Yes_____No _____

Applications for Expedited External Review may be faxed to (603) 271-1406 or sent by overnight carrier to the address on the top of this form. To email the appeal, please call the Insurance Department at 1-800-852-3416 for additional instructions.

Section VII – Request for a Telephone Conference

**** Complete this section, only if you would like to request a telephone conference ****

If the patient, the authorized representative or the treating health care provider would like to discuss this case with the Independent Review Organization and the insurer in a telephone conference, select "Yes" below and explain why you think it is important to be allowed to speak about the case. If you do not request a telephone conference, the reviewer will base its decision on the written information only. The request for a telephone conference will be granted only if there is a good reason why the written information would not be sufficient.

**** Telephone conferences often cannot be completed within the timeframe for expedited reviews ****

Do you request a telephone conference? Yes_____No _____

My reason for requesting a phone conference is:

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.

Sign Here

_____ _____

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

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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.

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

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

New Hampshire Insurance Department

REQUEST FOR INDEPENDENT EXTERNAL APPEAL OF A HEALTH CARE DECISION

ENROLLEE INFORMATION

Enrollee's Name: _____ Patient's Name: _____

Mailing Address: _____

_____

Phone Number: Daytime (_____)_____ Evening (_____)_____

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

INFORMATION ABOUT YOUR EMPLOYER

Employer's Name: _____

Employer's Phone Number: _____

Is the insurance you have through your employer a self-funded plan?_____ If you are not certain please check with your employer. These types of plans are not eligible for external review.

INFORMATION ABOUT YOUR MANAGED CARE INSURANCE COVERAGE

Health Insurance Company's Name: _____

Insurer Mailing Address: _____

_____

Insurer Telephone Number: (_____)_____

Person at Health Insurance Company Involved with Your Appeal: _____

INFORMATION ABOUT YOUR TREATING HEALTH CARE PROVIDER

Name of Health Care Provider: _____

Type of Provider: Medical Doctor Other (please specify): _____

Provider Mailing Address: _____

_____

Provider Phone Number: (_____)_____

APPOINTMENT OF AUTHORIZED REPRESENTATIVE

(Fill out this section only if someone else will be representing you in this appeal.)

You can 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)* Date

*(Parent, Guardian, Conservator, or Other – Please Specify)

Address of Authorized Representative: _____

_____

Phone Number: Daytime (_____)_____ Evening (_____)_____

REQUEST FOR A TELEPHONE CONFERENCE

(Fill out this section only if you would like to request a telephone conference.)

If you, your representative or your treating health care provider would like to discuss your case with the independent review organization and your insurer in a telephone conference, check the box below and explain why you think it is important to be allowed to speak about your case. If you do not request a telephone conference, the reviewer will base its decision on the written information only. Your request for a telephone conference will be granted only if there is a good reason why the written information would not be sufficient.

☐ Yes, I want a phone conference. My reason for requesting a phone conference is that _____

_____

_____.

HEALTH CARE DECISION IN DISPUTE

Describe your health insurer's decision in your own words. Include any information you have about the heath care services, supplies or drugs being denied, including dates and names of health care providers. Explain why you disagree with the insurer. Attach additional pages if necessary. Also attach pertinent medical records and (if possible) a statement from your treating health care provider indicating why the disputed service, supply, or drug is medically necessary.

_____

_____

_____

_____

_____

_____

_____

_____

EXPEDITED REVIEW

You may request that your external appeal be handled on an expedited basis. To complete this request, your treating health care provider must fill out the attached form stating that a delay would seriously jeopardize the life or health of the patient or would jeopardize the patient's ability to regain maximum function.

Is this a request for an expedited appeal? Yes_____ No_____

REQUEST FOR EXTERNAL REVIEW AND RELEASE OF MEDICAL RECORDS

I,_____, hereby request an external appeal and authorizemy insurance company and my health care providers to release all relevant medical or treatment records to the independent review organization and the New Hampshire Insurance Department. I understand that the independent review organization and the Insurance Department will use this information to make a determination on my appeal and that the information will be kept confidential and not be released to anyone else. I understand that neither the Commissioner nor the external appeal entity may authorize services in excess of those covered by my health care plan. This release is valid for one year.

_____ _____
Signature of Enrollee (or legal representative)* Date
*(Parent, Guardian, Conservator, or Other – Please Specify)

WHAT TO SEND AND WHERE TO SEND IT

- ☐ This completed application form signed and dated (see section above).
- ☐ A copy of the letter from your health insurer denying your request at the second and final level of their internal appeals process.
- ☐ A photocopy of your insurance card or other evidence that you are insured by the health insurance company named in this application.
- ☐ A copy of your certificate of coverage or your insurance policy benefit booklet, which lists your benefits.
- ☐ Any medical records, statements from your treating health care providers or other information that you would like the independent review organization to consider in reviewing your case.

Call the Insurance Department at 800-852-3416 or 271-2261 if you need help with this application or if you do not have one or more of the above items and would like information on alternative ways to complete your request for independent external review.

If you are requesting a standard review, send all paperworkto:

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

If you are requesting an expedited review, call the Insurance Department before sending your paperwork, and you will receive instructions on the quickest way to submit the application and supporting information.

New Hampshire Insurance Department

CERTIFICATION OF TREATING HEALTH CARE PROVIDER FOR EXPEDITED CONSIDERATION OF A PATIENT'S EXTERNAL APPEAL

NOTE TO THE TREATING HEALTH CARE PROVIDER:

Patients can request an independent external appeal when a managed care insurer has denied a health care service, supply or drug on the basis of a utilization review determination that the requested service, supply or drug does not meet the insurer's requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness. The New Hampshire Insurance Department oversees external appeals. The standard process for handling external review can take up to 52 days. Expedited review is available only if the patient's treating health care provider certifies that 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. Expedited review must be completed in at most 72 hours. This form is for the purpose of providing the certification necessary to trigger expedited review.

GENERAL INFORMATION:

Name of Treating Health Care Provider: _____

Mailing Address: _____

_____

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

Licensure and Area of Clinical Specialty: _____

_____

Name of Patient: _____

Patient's Health Insurer Member ID #: _____

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 appeal would, in my professional judgement, 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.

_____
Treating Health Care Provider's Name (Please Print)

_____ _____
Signature Date