DARTMOUTH COLLEGE

Standard Benefits 2005

Enrollment Information Booklet

For

Research Fellows and
Research Associate B Employees

For More Information

Anthem Blue Cross and Blue Shield of NH
Toll-free Phone Number:
1-800-437-9282
Web site: *www.anthem.com*

Behavorial Health Network
Toll-free Phone Number:
1-800-228-5975

CNA
Toll-free Phone Number:
1-800-528-4582
Web site: *www.cna.com*

Crosby Benefit Systems
Toll-free Phone Number:
1-800-462-2235
Web site: *www.CrosbyBenefits.com*

Northeast Delta Dental
Toll-free Phone Number:
1-800-832-5700
Web site: *www.nedelta.com*

MetLife
Toll-free Phone Number:
1-800-638-6420 (effective 1/1/05)
Web site: *www.metlifeiseasier.net*

Benefits Office
Phone Number:
(603) 646-3588
Email: Human.Resources.Benefits@Dartmouth.EDU
Web site: *www.dartmouth.edu/~hrs*

Table of Contents

Page

What's New in 2005 1

Your Benefit Options 2

Medical Plans 3

Indemnity Plan 3
- Plan Features
- Table

Preferred Blue Plan (PPO) 4
- Plan Features
- Table

Blue Choice Plan (POS) 6
- Plan Features
- Table

Dental Plan 8

How to Enroll 9

Enrollment Form Instructions 10
- Medical Plan Monthly Prices
- College Contribution

Glossary of Benefit Terms 11

Election Options for 2005

This booklet will provide an overview of the Standard Benefit program offered to Research Fellows and Research Associate B employees. It contains a summary of your benefit choices and includes important reminders, changes for 2005, and information about how to use your personalized enrollment worksheet.

Your Choices

Open Enrollment is held annually each fall. This gives you the opportunity to choose the benefit options that are right for you and your family for the upcoming year. You can make elections or changes to the following options:

- Medical Insurance
- Dental Insurance
- Life Insurance
- LTC (excludes Research Fellows)

For More Information

The benefits you elect will remain in effect for the entire calendar year of 2005 unless you have a qualified change in family or employment status. You can find more information about these and other benefits available to you at www.dartmouth.edu/~hrs/ or in the Summary Plan Description. A glossary of benefit terms can be found at the end of this booklet.

This booklet is not the Plan document for any of the Plans, but only a summary of coverage and benefits under the Plans. Not every limitation or detail of any of the Plans is included in this booklet. Every attempt has been made to provide concise and accurate information. However, if there is a discrepancy between this booklet and the official Plan document for any of the Plans or the Certificate of Coverage issued by Anthem Blue Cross and Blue Shield of NH, Northeast Delta Dental, or MetLife Insurance Company, the Plan document or Certificate of Coverage shall control.

The College has a right to change or terminate these benefits, including in the middle of a year, at its discretion. Change may be approved by the Board of Trustees (or its Executive Committee), the President, or Executive Vice-President and Treasurer of the College, or by another official to whom one of these has delegated the amendment power. If you have questions about these or any benefits at Dartmouth College, call the Benefits Office at (603) 646-3588.

What's New in 2005?

There are several changes to Dartmouth's benefit options for 2005. You should carefully review your current benefits to be sure that your selections continue to be the appropriate choices for you and your family. If you wish to make a change, you must complete the personalized enrollment form, which indicates your 2005 costs. Submit it to the Benefits Office between October 18 and November 5, 2004.

Medical and Dental Rates

The 2005 Medical and Dental rates, while increasing, will continue to be below national and regional averages. Both the College, and the faculty and staff, share in the rising cost for health care coverage. The College continues evaluating benefit plans and factors which impact the issue of rising health care cost.

Life Insurance Change

Met Life, a leading provider of insurance and financial products and services, is Dartmouth's life insurance carrier, effective January 1, 2005. Rates will decrease across the board.

For those employees who choose basic life (2.5 times salary), rates will decrease by 17%.

Long-Term Care

During 2005 Open Enrollment, CNA Insurance Company is extending a guaranteed issue for employees. This means that employees enrolling in the long-term care plan during the open enrollment period will not be required to complete a medical history statement. Long-term care insurance for a spouse, parents, parents-in-law, grandparents, and grandparents-in-law will continue to require a medical history statement and CNA Insurance Company approval. If you are interested in obtaining more information, please contact the CNA at 1-800-528-4582.

Anthem Website Enhancements

MyAnthem online member services makes it easy for you and registered family members to use and work with your health plan. You can conveniently and securely perform many membership-related functions and obtain up-to-the minute health and benefit information. For instance, you can search the Provider Directory, access your claims information, view your membership information, change your primary care physician, order prescriptions, and request new ID cards.

Additionally, Anthem offers online tools such as *MyHealth*, which includes health and wellness information, interactive games for children to learn about living with a chronic illness, and services for Spanish speakers. *SpecialOffers* gives discounts on health-related products and services. Visit www.anthem.com to register.

If you suffer from a chronic problem such as diabetes, heart disease, or asthma, Anthem is offering a free "disease management program" to prevent your condition from worsening. This program is for members wishing to have assistance with treating chronic conditions and effectively containing costs. Please contact the Anthem customer service line at 1-800-437-9282 for further details.

Your Benefit Options

Levels of Coverage. You may choose individual, two-person, or family coverage for medical, dental, or dependent life insurance. Two-person or family coverage includes your spouse, same-sex domestic partner, and unmarried dependent children up to age 19 or up to age 25 if full-time students. Please refer to the Summary Plan Description for further details regarding eligible dependents and the tax implications of domestic partner coverage.

Medical

Dartmouth offers three different health plan choices covering medical needs ranging from catastrophic expenses to preventive and routine care. You can elect either the Indemnity plan; Preferred Blue, a Preferred Provider Organization (PPO) plan; or Blue Choice, a Point of Service (POS) managed care plan. All plans are administered by Anthem Blue Cross and Blue Shield of New Hampshire. The customer service line for Anthem is 1-800-437-9282, or you can visit their Web site at www.anthem.com.

Three Medical Plans

Indemnity

Preferred Blue (PPO)

Blue Choice (POS)

Dental

Premier Dental plan is with Northeast Delta Dental. It offers preventative coverage at 100%, restorative at 80%, and prosthodontics at 50%. The maximum annual coverage is $1500 for each member. The plan does not provide coverage for orthodontia. For a list of providers, visit the Delta Web site at www.nedelta.com, or contact the customer service line for Northeast Delta Dental at 1-800-832-5700 .

Life Insurance

You have options of up to 2.5 times your annual salary. The College will also provide Accidental Death and Dismemberment coverage equal to your life insurance coverage up to $250,000. The first time you elect life insurance at Dartmouth College, you are not required to provide information about your health for any amount of coverage up to 2.5 x pay, unless 2.5 times your salary is $500,000 or greater. If you wish to increase your coverage amount during open enrollment, you must complete a Statement of Health and mail it directly to MetLife Insurance Company. The change in coverage will become effective after we receive an approval from MetLife.

Long-Term Care

Additionally, Dartmouth College offers a Long-Term Care plan through CNA Insurance Company, at group rates through post-tax payroll deductions. It is not included as part of the benefit plan. If you are interested in learning more about the plan or wish to apply, please contact the CNA at 1-800-528-4582 for an information packet. New hires can enroll without a Medical History Statement within 30 days of hire or notification of eligibilty. You can also enroll your spouse, parents, parents-in-law, grandparents, and grandparents-in-law. A Medical History Statement is required for family members and for employees enrolling past the initial 30 days. This is a portable plan, so if you leave Dartmouth in the future, CNA will continue your plan on a home billing basis.

Medical Plans

Indemnity Plan

An Indemnity Medical Plan is a fee-for-service plan where subscribers are responsible for paying a deductible for medical expenses. When the out-of-pocket maximum is reached, this plan pays covered expenses at 100% up to the Maximum Allowable Benefit (MAB). Please note that mental health, alcohol, and drug treatment have a coinsurance amount of 20% once the deductible is reached. The $1,500 is an accumulation of the MAB for eligible expenses.

Important Features

Maximum Allowable Benefit (MAB) – Medical claims covered by the plan are paid according to the Maximum Allowable Benefit, determined by Anthem Blue Cross and Blue Shield of NH (Anthem BCBSNH). When services are received outside the state of New Hampshire, Anthem BCBSNH will use the Maximum Allowable Benefit of that state's Blue Cross organization to determine the appropriate payment.

Participating Provider – Subscribers are protected from paying charges over and above the MAB when they receive services from a participating provider. For up-to-date information on participating providers, call Anthem BCBSNH at 1-800-437-9282 or visit their Web site at: www.anthem.com.

3-Month Carry-Over of Deductible – Medical expenses incurred in the last three months of a calendar year (October, November, December) which were applied toward the covered member's deductible, will also count toward that member's Indemnity deductible in the following calendar year.

Mental Health, Alcohol, and Drug Treatment – Unlike other covered expenses, covered mental health, alcohol, and drug treatment are always paid at the 20% coinsurance after the member has met their deductible.There is no out-of-pocket maximum for these expenses.

Prescription Drugs – Prescription drugs are covered the same way as any other eligible expense and are processed by Anthem Prescription Management. You pay the full cost of your prescription up front and are reimbursed by Anthem BCBSNH after you have met your deductible.

Indemnity Medical Plan			
Medical Plan	**Amount of Deductible**	**Co-insurance (% paid by subscriber)**	**Annual Out-of-Pocket Maximum**
Indemnity	$1,500 individual $3,000 two-person or family	N/A*	$1,500 individual $3,000 two-person or family

*The co-insurance amount is paid at 20% for mental health, alcohol, and drug treatment claims after you have met your annual out-of-pocket maximum.

Preferred Blue (PPO)

Preferred Blue is a Preferred Provider Organization (PPO). The PPO is similar to an indemnity plan in that participants coordinate their own care and are not required to get a referral from a primary care physician (PCP). The PPO allows availability to national networks of doctors, hospitals, and other care providers.

Important Features

Maximum Allowable Benefit – Services are covered up to the Maximum Allowable Benefit (MAB). Network providers agree to accept the MAB as payment in full. However, if you receive services from an out-of-network provider, it is your responsibility to pay the difference between the MAB and the provider's charge.

Referrals – The PPO plan offers PPO members the ability to see any specialty physician without referral from a PCP.

In-Network – Refers to the use of providers who participate in the health benefit plan's provider network. A PPO requires members to use participating providers to receive the highest reimbursement.

Out-of-Network – Refers to the use of providers who are out of the network. PPO members can go out of network but may pay some additional costs.

Mental Health and Substance Abuse Services – To receive in-network benefits for these services, you must call the Behavioral Health Network (BHN) at 1-800-228-5975. They will refer you to a network provider. You are not required to consult your PCP for these services. If you choose to receive alcohol, drug, or mental health services from a non-BHN network provider, these services would be covered as out of network. You will still need to call BHN to notify them that you are receiving care from an out-of-network provider so that Anthem can process your claims correctly.

Prescription Drugs – The cost of prescription drugs is $5 for generic, $15 for formulary brand, or $30 for non-formulary brand. You can also obtain a 90-day supply at these rates by placing a mail order with Anthem Prescription Management. Call 1-800-962-8192 or visit the www.anthem.com Web site for member services.

Routine Eye Exam– Preferred Blue provides for one routine eye exam per year for each member 18 years old or younger and one exam every two years for members 19 years old or older.

Covered Services	*Preferred Blue® (PPO)*	
	Network	**Out-of-Network**
Physician Services Office visit, specialist visit, physical exam, routine GYN visit, well child office visit- (2 years and older) Well baby office visit (under 2 years old)	$15 co-pay per visit	$500 deductible No more than $1,500 per family each year 20% co-insurance No more than $1,000 per member each year, no more than $3,000 per family per calendar year Some out-of-network benefits are subject to precertification requirements. Refer to your Subscriber Certificate for details. Annual out-of-pocket, maximum $1,500 per individual $4,500 per family
Childhood Immunizations	You pay $0	
Outpatient Services Medical exam, injections (including allergy injections), office surgery and anesthesia	$15 per visit	
Lab, X-ray and ultrasound	Covered in full	
Inpatient Hospital Services Semi-private room and board Physician in-hospital care, maternity care, surgery, anesthesia, lab, X-ray, CT scan, MRI, medical supplies, medication and physical, occupational and speech therapy	Subject to: $250 deductible per member, no more than $750 per family per calendar year Covered at 100% after the deductible is met	
Skilled Nursing Facility and Physical Rehabilitation Facility (100 days per member per calendar year for each)	You pay $0	
Hospice Services	You pay $0	
Home Health Services (Subject to medical necessity)	You pay $50	
Physical and Occupational Therapy, Speech Therapy (Combined $5,000 per member per calendar year)	$15 co-pay per visit	
Emergency Room	You pay $75 ($0 if admitted)	
Ambulance (Subject to medical necessity)	Deductible/co-insurance	Same as network
Chiropractic Services (Maximum of 20 visits per year)	You pay $15	Subject to deductible/co-insurance
Inpatient Mental Health & Substance Abuse Services*	Subject to deductible/co-insurance	Subject to deductible/co-insurance
Outpatient Mental Health & Substance Abuse Services*	You pay $15 when arranged through BHN	Subject to deductible/co-insurance
Prescription Drug	$5 co-pay / generic $15 co-pay / formulary brand $30 co-pay / non-formulary brand Co-payment applies to each fill, up to a 31-day supply for retail. A 90-day supply through mail order requires one (1) co-payment.	

*Care is arranged through Behavioral Health Network (BHN) by calling 1-800-228-5975.

Blue Choice

Blue Choice is a managed care, Point of Service (POS) plan. If you elect Blue Choice, you must have a Primary Care Physician for you and your dependent(s) in order to receive network benefits. The Blue Choice chart outlines the three options available to you in this plan. The network for Blue Choice refers to NH-based and some VT providers.

Important Features

Primary Care Physician (PCP) – If you elect Blue Choice, you should call Anthem Blue Cross and Blue Shield within thirty (30) days of enrollment to choose a Primary Care Physician (PCP) from the Blue Choice network of providers, for yourself and any family members you are covering under the plan. To choose your PCP or to find out about physicians in the network, call 1-800-437-9282 or visit the Anthem Web site at www.anthem.com.

Option 1 Benefits – What you receive when you go to your PCP or to a provider you are referred to by your PCP.

Option 2 Benefits – What you receive when you use a Blue Choice network provider but are not referred by your PCP.

Option 3 Benefits – What you receive when you go out of network. You will need to call Blue Choice Managed Care at 1-800-531-4450 to precertify certain services.

Mental Health and Substance Abuse Services – To receive Option 1 benefits for these services, you must call the Behavioral Health Network (BHN) at 1-800-228-5975. They will refer you to a network provider. You are not required to consult your PCP for these services. If you choose to receive alcohol, drug, or mental health services from a non-BHN network provider, these services would be covered under Option 3. You will still need to call BHN to notify them that you are receiving care from an out-of-network provider so that Anthem can process your claims correctly.

Prescription Drugs – The cost of prescription drugs is $5 for generic, $15 for formulary brand, or $30 for non-formulary brand. You can also obtain a 90-day supply at these rates by placing a mail order with Anthem Prescription Management. Call 1-800-962-8192 or visit the www.anthem.com Web site for member services.

Annual Eye Exam – Blue Choice provides for one annual eye exam from a network provider, subject to the $10 office visit co-payment, and a $40 reimbursement toward the cost of frames, lenses, and contacts in conjunction with the exam. This is also available under Option 3, subject to the deductible.

Fitness Incentive – A Blue Choice subscriber can receive up to $200 reimbursement for the cost of joining a participating health club. Proof of exercise is required. For details call 1-800-437-9282, or refer to the "Your Lifestyle" directory.

BLUE CHOICE COVERED SERVICES	WHAT YOU PAY WHEN YOUR PCP PROVIDES OR ARRANGES YOUR CARE Option 1	WHAT YOU PAY WHEN YOU SEEK CARE DIRECTLY FROM ANY BLUE CHOICE NETWORK PROVIDER Option 2	WHAT YOU PAY WHEN YOU SEEK CARE FROM ANY OUT-OF-NETWORK PROVIDER Option 3
Physician Services Office visit, Specialist visit, Physical exam, Well child office visit (2 years and older)	$10 per visit	$25 per visit	$300 deductible No more than $900 per family each year 20% co-insurance No more than $1,200 per member/$3,600 per family each year
Routine GYN visit	N/A	$10 per visit	
Well baby office visit (under 2 years old)	You pay $0	You pay $0	
Childhood Immunizations		$150 deductible No more than $450 per family each year 20% co-insurance No more than $900 per member/ $2,700 per family each year	
Surgical Services, Inpatient medical care, Diagnostic testing, Maternity care			
Outpatient Services			
Inpatient Hospital Services			
Skilled Nursing Facility and Rehabilitation Facility (100 day maximum)			
Home Health Services (Subject to medical necessity)			
Hospice Services			
Physical Therapy, Speech Therapy, and Occupational Therapy ($5,000 maximum per member per year)			
Ambulance (Subject to medical necessity)		You pay $0	You pay $0
Chiropractic Office Visits (20 visits - no PCP referral required)	N/A	$10 per visit	Subject to deductible and co-insurance
Inpatient Mental Health and Substance Abuse Services (Care is arranged through Behavioral Health Network)	You pay $0	N/A	
Outpatient Mental Health and Substance Abuse Services (Care is arranged through Behavioral Health Network)	$10 per visit		
Emergency Room (Additional charges like lab and x-rays subject to deductible and co-insurance if PCP is not called within 48 hours.)	$50 co-payment ($0 if admitted)	$50 co-payment ($0 if admitted)	$75 co-payment ($0 if admitted; Option 1 co-payment if condition is life threatening)
Prescription Drugs	$5 co-pay / generic $15 co-pay / formulary brand $30 co-pay / non-formulary brand Co-payment applies to each fill, up to a 31-day supply for retail. A 90-day supply through mail order requires one (1) co-payment.		
Routine Vision Care (no PCP referral required)	Annual exam for adults and children. $40 reimbursement toward eyewear.		
Maximum Lifetime Benefit	Unlimited		
Fitness Reimbursement	Up to $200 per family, per year		

Dental Plan

Northeast Delta Dental is the dental insurance carrier. The Premier Dental plan offers preventive coverage at 100%, restorative at 80%, and prosthodontics at 50%. The annual coverage is up to $1500 for each member. The plan does not provide coverage for orthodontia. For a list of providers, visit the Web site at www.nedelta.com or call the customer service department (1-800-832-5700).

Important Features

This plan does not have a deductible. Benefits are paid at a coinsurance amount, based on the Usual, Reasonable, and Customary charge established by Northeast Delta Dental.

Please Note:
Orthodontia is not covered under this plan.

When members go to a participating dentist, they are protected from paying any amount over and above the Usual, Reasonable, and Customary charge. To find out if a dentist is in the Northeast Delta Dental network, call the Customer Service Department (1-800-832-5700), visit the Web site (www.nedelta.com), or call the dentist's office.

There is no waiting period for coverage.

PREMIER DENTAL PLAN			
Dental Services	**Amount of Coverage by Insurance**	**Amount of Cost to You**	**Annual Maximum of Combined Services**
Diagnostic/Preventative care	100%	0%	$1500 per person per calendar year
Basic Restorative care	80%	20%	
Major Restorative/ Prosthodontics	50%	50%	
Orthodontia	no coverage		

DENTAL COST (MONTHLY)		
Single	**Two Person**	**Family**
$37.61	$66.95	$115.57

How to Enroll

Enrollment in five easy steps

1. Review this booklet for important plan information.
2. Complete the enclosed Standard enrollment form. During open enrollment, you need to do this only if you are making changes.
3. If you wish to change or designate your life insurance beneficiary, please complete the enclosed Beneficiary Form.
4. Return these two forms to the Benefits Office in the provided envelope **by the deadline.**
5. If you are increasing your life insurance coverage, the Benefits Office will send you a Statement of Health form. The form should be sent directly to The MetLife Insurance Company for approval. The address is on the form.

Other important points

Deadline: During open enrollment you must return your forms to the Benefits office by November 5, 2004. If you do not return an enrollment form during open enrollment, you will remain in the same plan which you are presently enrolled.

New Hire: If you are a new hire, you must elect benefits within thirty (30) days from your date of hire or attendance at orientation, or you will be enrolled in the default coverage. Default coverage is the Indemnity medical plan. If you have coverage elsewhere, elect no coverage and return the form by the due date or you will be defaulted into the Indemnity Medical Plan.

Address Changes: Anthem Blue Cross and Blue Shield of New Hampshire and Northeast Delta Dental receive your address electronically from Dartmouth College. If your address changes, please notify the Dartmouth Payroll Office by email at Dartmouth.payroll@dartmouth.edu and request a change to your benefits address or complete an Employee Information Change Form.

Dependent Student: If you have a dependent that has reached the age of 19 and is enrolled full-time in an accredited college (twelve credits per semester), you must provide a Student Certification Form to Anthem Blue Cross and Blue Shield of New Hampshire and Northeast Delta Dental each year during the month of their birthday. If Anthem or Delta does not receive the form, they will not know that your dependent is an eligible dependent, and the coverage will automatically end on the last day of the month of their birthday.

THE STANDARD ENROLLMENT FORM
Purchasing Your Benefits

Note: Your current elections are indicated with a large "X" next to each option.

YOUR DEPENDENTS

Review the dependents' information listed, and make necessary changes, additions, or deletions.

MEDICAL

1. Circle the option you wish to elect, and write the cost in the boxes on the right side of the form.

2. **College Contribution:** Your Standard Medical Credit is the contribution toward your medical insurance. This amount is based on your medical election. Your allowance is shown on your enrollment form. Use the medical credit according to the number of dependents you are covering on medical insurance (i.e., no coverage, single, two-person, or family).

3. **Calculate your costs:** Subtract your medical credit from your total costs and write the difference in the final box.

DENTAL AND LIFE INSURANCE

Circle the option you wish to elect, and write the cost in the boxes on the right side of the form.

ADDING IT ALL UP

1. Add your elected options and enter this amount in the appropriate box.
2. **Your final costs:** If the cost exceeds the credit, you will have a payroll deduction from your salary, which is pre-tax for Research Associate B, but after tax for Research Fellows.

MEDICAL OPT OUT

If you elect no medical coverage, write the information of your current plan in the space provided.

YOUR AUTHORIZATION

After you have reviewed the terms of the elections and have completed your enrollment form, sign and date the form.

Medical Plan Monthly Prices

Medical Plans	One-Person	Two-Person	Family
Option 1—No Coverage	$0	$0	$0
Option 2—Indemnity	$382.82	$765.63	$1033.59
Option 3—Preferred Blue	$406.75	$813.47	$1098.20
Option 4—Blue Choice	$398.63	$797.53	$1076.68

College Contribution

One-Person	Two-Person	Family
$383.00	$646.00	$872.00

*Part-time appointments receive pro-rated amount.

Glossary of Benefit Terms

BENEFICIARY
An individual designated by the employee to receive proceeds or benefits from the employee's life insurance or retirement plans.

CHANGE IN STATUS
A life event such as marital status change, birth or death of a dependent, dependent eligibility change, or job status change, that allows an employee to change benefit elections at a time other than Open Enrollment.

COBRA (CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT)
A Federal Law that allows employees and their dependents to continue insurance coverage after a qualifying event such as a loss of eligibilty or termination of employment resulting in a loss of coverage. Cost is at the total premium rate, plus an administration fee.

CO-INSURANCE
After the deductible has been paid, this is a percentage the member pays for covered services.

CO-PAYMENT
A fixed dollar amount you pay for certain services under a managed care plan or Preferred Provider Organization.

DEDUCTIBLE
The annual out-of-pocket payment that you make before the plan begins to pay for your health care.

DEPENDENT
An individual such as a child, same-sex domestic partner, or spouse that is eligible for coverage under the employee's insurance plans.

INDEMNITY PLAN
This plan requires subscribers to pay a set deductible before the plan pays any of the cost of health care. Participants also pay a co-insurance amount for some ongoing services.

MANAGED CARE/POINT-OF-SERVICE PLAN (BLUE CHOICE)
A plan that has a fixed co-payment amount for medical expenses, if using a Primary Care Provider. It has a network of preferred providers, and options with deductibles for out-of network services.

NETWORK
Hospitals and providers having an agreement with a health plan company to make covered services available to members.

OPEN ENROLLMENT
The annual period during which employees re-enroll or have the option to change their benefit selections.

OUT-OF-NETWORK
Services that you receive from a non-participating provider. Services require deductible and co-insurance payments.

OUT-OF-POCKET MAXIMUM
The deductible amount added to your co-insurance maximum. Once the out-of-pocket maximum is met, covered services are paid at 100% of the allowed charge for the rest of the calendar year. Co-payment amounts will continue to apply.

PREFERRED PROVIDER ORGANIZATION (PPO)
A PPO health insurance plan has a network of participating providers who are local, national and international. This plan has a fixed co-payment amount for medical expenses in the network and deductible and co-insurance for expenses incurrred outside the network.

PREMIUM
Payment made on an insurance policy on a regular, periodic basis.

PRIMARY CARE PROVIDER (PCP)
A physician who coordinates health services and issues referrals for an employee or covered dependents. Also known as a Primary Care Physician.

REFERRAL
The approved authorization or recommendation from your Primary Care Provider for medical services.

SINGLE COVERAGE
Coverage for an employee only.

HR The Office of Human Resources at Dartmouth College
7 Lebanon Street • Suite 203 • Hanover • New Hampshire • 03755-2112

October 2004