**Summary of Benefits and Coverage:** What this Plan Covers & What You Pay For Covered Services

**Trustees of Dartmouth College: High Deductible Health Plan with HSA (HDHPQ)**

**Coverage Period:** 01/01/2024 - 12/31/2024

**Coverage for:** Individual/Individual + Family | **Plan Type:** OAP

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The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, go online at [www.cigna.com/sp](http://www.cigna.com/sp). For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms, see the Glossary. You can view the Glossary at [https://www.healthcare.gov/sbc-glossary](https://www.healthcare.gov/sbc-glossary) or call 1-800-Cigna24 to request a copy.

### Important Questions

<table>
<thead>
<tr>
<th><strong>What is the overall deductible?</strong></th>
<th><strong>Answers</strong></th>
<th><strong>Why This Matters:</strong></th>
</tr>
</thead>
</table>
| For **in-network providers**: $3,200/individual - employee only or $6,400/family maximum (no more than $3,200 per individual - within a family)  
For **out-of-network providers**: $4,100/individual - employee only or $8,200/family maximum (no more than $4,100 per individual - within a family)  
Combined medical/behavioral and pharmacy deductible | Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible. |

| **Are there services covered before you meet your deductible?** | Yes. In-network preventive care & immunizations. | This plan covers some items and services even if you haven’t yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at [https://www.healthcare.gov/coverage/preventive-care-benefits/](https://www.healthcare.gov/coverage/preventive-care-benefits/). |

| **Are there other deductibles for specific services?** | No. | You don’t have to meet deductibles for specific services. |

| **What is the out-of-pocket limit for this plan?** | For **in-network providers**: $4,200/individual - employee only or $8,400/family maximum (no more than $4,200 per individual - within a family)  
For **out-of-network providers**: $6,500/individual - employee only or $13,000/family maximum (no more than $6,500 per individual - within a family)  
Combined medical/behavioral and pharmacy out-of-pocket limit | The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met. |

| **What is not included in the out-of-pocket limit?** | Penalties for failure to obtain pre-authorization for services, premiums, balance-billing charges, and health care this plan doesn’t cover. | Even though you pay these expenses, they don’t count toward the out-of-pocket limit. |
## Important Questions

<table>
<thead>
<tr>
<th>Important Questions</th>
<th>Answers</th>
<th>Why This Matters:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Will you pay less if you use a network provider?</td>
<td>Yes. See <a href="http://www.cigna.com">www.cigna.com</a> or call 1-855-869-8619 for a list of network providers.</td>
<td>This plan uses a provider network. You will pay less if you use a provider in the plan’s network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider’s charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.</td>
</tr>
<tr>
<td>Do you need a referral to see a specialist?</td>
<td>No.</td>
<td>You can see the specialist you choose without a referral.</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>What You Will Pay</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>If you visit a health care provider's office or clinic</td>
<td>Primary care visit to treat an injury or illness</td>
<td>10% coinsurance/visit 30% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Specialist visit</td>
<td>10% coinsurance/visit 30% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Preventive care/ screening/ immunization</td>
<td>No charge Deductible does not apply 30% coinsurance</td>
<td>You may have to pay for services that aren’t preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.</td>
</tr>
<tr>
<td>If you have a test</td>
<td>Diagnostic test (x-ray, blood work)</td>
<td>10% coinsurance 30% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Imaging (CT/PET scans, MRIs)</td>
<td>10% coinsurance 30% coinsurance</td>
<td>$500 penalty for no out-of-network precertification.</td>
</tr>
<tr>
<td>If you need drugs to treat your illness or condition</td>
<td>Generic drugs (Tier 1)</td>
<td>Not covered</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Preferred brand drugs (Tier 2)</td>
<td>Not covered</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Non-preferred brand drugs (Tier 3)</td>
<td>Not covered</td>
<td>Not covered</td>
</tr>
<tr>
<td>More information about prescription drug</td>
<td></td>
<td></td>
<td>Coverage provided by Express Scripts.</td>
</tr>
<tr>
<td>Common Medical Event</td>
<td>Services You May Need</td>
<td>What You Will Pay</td>
<td>Limitations, Exceptions, &amp; Other Important Information</td>
</tr>
<tr>
<td>----------------------------------------------------------</td>
<td>-----------------------------------------------</td>
<td>--------------------------------------------------</td>
<td>--------------------------------------------------------</td>
</tr>
<tr>
<td></td>
<td></td>
<td>In-Network Provider</td>
<td>Out-of-Network Provider</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(You will pay the least)</td>
<td>(You will pay the most)</td>
</tr>
<tr>
<td>coverage is available at <a href="http://www.express-scripts.com">www.express-scripts.com</a></td>
<td>Specialty drugs (Tier 4)</td>
<td>Not covered</td>
<td>Not covered</td>
</tr>
<tr>
<td>If you have outpatient surgery</td>
<td>Facility fee (e.g., ambulatory surgery center)</td>
<td>10% coinsurance</td>
<td>30% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>10% coinsurance</td>
<td>30% coinsurance</td>
</tr>
<tr>
<td></td>
<td></td>
<td>$500 penalty for no out-of-network precertification.</td>
<td></td>
</tr>
<tr>
<td>If you need immediate medical attention</td>
<td>Emergency room care</td>
<td>10% coinsurance</td>
<td>10% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Emergency medical transportation</td>
<td>10% coinsurance</td>
<td>10% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Urgent care</td>
<td>10% coinsurance</td>
<td>10% coinsurance</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Out-of-network services are paid at the in-network cost share and deductible.</td>
<td></td>
</tr>
<tr>
<td>If you have a hospital stay</td>
<td>Facility fee (e.g., hospital room)</td>
<td>10% coinsurance</td>
<td>30% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>10% coinsurance</td>
<td>30% coinsurance</td>
</tr>
<tr>
<td></td>
<td></td>
<td>$500 penalty for no out-of-network precertification.</td>
<td></td>
</tr>
<tr>
<td>If you need mental health, behavioral health, or substance abuse services</td>
<td>Outpatient services</td>
<td>10% coinsurance/office visit</td>
<td>First 12 visits per Lifetime 10% coinsurance</td>
</tr>
<tr>
<td></td>
<td></td>
<td>10% coinsurance/all other services</td>
<td>13th visit and after 10% coinsurance/office visit</td>
</tr>
<tr>
<td></td>
<td>Inpatient services</td>
<td>10% coinsurance</td>
<td>30% coinsurance/office visit</td>
</tr>
<tr>
<td></td>
<td></td>
<td>$500 penalty if no precert of out-of-network non-routine services (i.e., partial hospitalization, etc.).</td>
<td></td>
</tr>
<tr>
<td>If you are pregnant</td>
<td>Office visits</td>
<td>10% coinsurance</td>
<td>30% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery professional services</td>
<td>10% coinsurance</td>
<td>30% coinsurance</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Primary Care or Specialist benefit levels apply for initial visit to confirm pregnancy.</td>
<td></td>
</tr>
<tr>
<td>Common Medical Event</td>
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<td>-------------------------------------------------</td>
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<td></td>
<td></td>
<td><strong>In-Network Provider (You will pay the least)</strong></td>
<td><strong>Out-of-Network Provider (You will pay the most)</strong></td>
</tr>
<tr>
<td></td>
<td></td>
<td>10% coinsurance</td>
<td>30% coinsurance</td>
</tr>
<tr>
<td>Childbirth/delivery facility services</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Home health care</td>
<td>10% coinsurance</td>
<td>30% coinsurance</td>
<td>$500 penalty for no out-of-network precertification. 16 hour maximum per day</td>
</tr>
<tr>
<td>Rehabilitation services</td>
<td>10% coinsurance/visit</td>
<td>30% coinsurance/visit</td>
<td>$500 penalty for failure to precertify out-of-network speech therapy services. Coverage is limited to annual max of: 80 days for Rehabilitation services; 36 days for Cardiac rehab services; 20 days for Chiropractic care services. Limits are not applicable to mental health conditions for Physical, Speech and Occupational therapies.</td>
</tr>
<tr>
<td>Habilitation services</td>
<td>10% coinsurance/visit</td>
<td>30% coinsurance/visit</td>
<td>$500 penalty for failure to precertify out-of-network speech therapy services. Services are covered when Medically Necessary to treat a mental health condition (e.g. autism) or a congenital abnormality. Limits are not applicable to mental health conditions for Physical, Speech and Occupational therapies.</td>
</tr>
</tbody>
</table>

Cost sharing does not apply for preventive services. Depending on the type of services, a copayment, coinsurance or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
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<td></td>
<td>In-Network Provider</td>
<td>Out-of-Network Provider</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(You will pay the least)</td>
<td>(You will pay the most)</td>
</tr>
<tr>
<td></td>
<td>Skilled nursing care</td>
<td>10% coinsurance</td>
<td>30% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Durable medical equipment</td>
<td>10% coinsurance</td>
<td>30% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Hospice services</td>
<td>10% coinsurance/inpatient services</td>
<td>30% coinsurance/inpatient services</td>
</tr>
</tbody>
</table>

**If your child needs dental or eye care**

|                      | Children's eye exam | Not covered | Not covered | None |
|                      | Children's glasses  | Not covered | Not covered | None |
|                      | Children's dental check-up | Not covered | Not covered | None |

**Excluded Services & Other Covered Services:**

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

- Cosmetic surgery
- Dental care (Adult)
- Dental care (Children)
- Eye care (Children)
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Prescription drugs
- Private-duty nursing
- Routine eye care (Adult)
- Routine foot care
- Weight loss programs

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

- Acupuncture (20 days)
- Bariatric surgery (if you qualify for coverage)
- Chiropractic care (20 days)
- Hearing aids (1 device per 36 months)
- Infertility treatment ($15,000 lifetime maximum)
Your Rights to Continue Coverage:
There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Department of Labor’s Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. Other coverage options may be available to you, too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights:
There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information on how to submit a claim, appeal or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: Cigna Customer service at 1-800-Cigna24. You may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. Additionally, a consumer assistance program can help you file your appeal. Contact: New Hampshire Department of Insurance at (800) 852-3416.

Does this plan provide Minimum Essential Coverage? Yes
Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

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

Language Access Services:
Spanish (Español): Para obtener asistencia en Español, llame al 1-800-244-6224.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-244-6224.
Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-800-244-6224.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijjigo holne’ 1-800-244-6224.

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

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

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

- The plan's overall deductible: $3,200
- Specialist coinsurance: 10%
- Hospital (facility) coinsurance: 10%
- Other coinsurance: 10%

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

**Total Example Cost** $12,700

**In this example, Peg would pay:**

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$3,200</td>
</tr>
<tr>
<td>Copayments</td>
<td>$0</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$900</td>
</tr>
</tbody>
</table>

*What isn’t covered*

| Limits or exclusions | $30 |

**The total Peg would pay is** $4,130

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

- The plan's overall deductible: $3,200
- Specialist coinsurance: 10%
- Hospital (facility) coinsurance: 10%
- Other coinsurance: 10%

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

**Total Example Cost** $5,600

**In this example, Joe would pay:**

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$1,140</td>
</tr>
<tr>
<td>Copayments</td>
<td>$0</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$0</td>
</tr>
</tbody>
</table>

*What isn’t covered*

| Limits or exclusions | $4,300 |

**The total Joe would pay is** $5,440

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

- The plan's overall deductible: $3,200
- Specialist coinsurance: 10%
- Hospital (facility) coinsurance: 10%
- Other coinsurance: 10%

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

**Total Example Cost** $2,800

**In this example, Mia would pay:**

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$2,790</td>
</tr>
<tr>
<td>Copayments</td>
<td>$0</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$0</td>
</tr>
</tbody>
</table>

*What isn’t covered*

| Limits or exclusions | $10 |

**The total Mia would pay is** $2,800

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

**Plan Name:** HDHPQ  **Ben Ver:** 29  **Plan ID:** 17026660