Student Health Insurance

Designed for the Students of

BENNINGTON COLLEGE

2016-2017

Underwritten by:
Nationwide Life Insurance Company
Columbus, OH
Policy Number: 302-055-4414

Effective: August 15, 2016 to August 14, 2017
Group Number: S210814

IMPORTANT NOTICE

This brochure provides a brief description of the important features of the Policy. It is not a Policy. Terms and conditions of the coverage are set forth in the Policy. We will notify Covered Persons of all material changes to the Policy. Please keep this material with your important papers.

NONDISCRIMINATORY

Health care services and any other benefits to which a Covered Person is entitled are provided on a nondiscriminatory basis, including benefits mandated by state and federal law.

Administered by:

CHP Student

Consolidated Health Plans
2077 Roosevelt Ave.
Springfield, MA 01104

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WHERE TO FIND HELP

For questions about claims status, eligibility, enrollment and benefits please contact:

For Questions About:	Please Contact:
Bennington College Student Health Services	**Health Services Coordinator** healthservices@bennington.edu (802)-440-4426
Waiver Process Enrollment Dependent Enrollment Insurance Benefits Claims processing	**Consolidated Health Plans** 2077 Roosevelt Avenue Springfield, Massachusetts 01104 (800) 633-7867 **www.chpstudent.com**
Preferred Provider Listings	Cigna PO Box 188061 Chattanooga, TN 37422-8061 **www.cigna.com**
Preferred PPO Provider Listings	**www.cigna.com** **(800) 633-7867**
Prescription Drug Providers	**Cigna Pharmacy** **www.cigna.com** **(800) 633-7867**

AM I ELIGIBLE?

Bennington College is making available a Student Health Insurance program (hereinafter called "plan") underwritten by Nationwide Life Insurance Company and administered by Consolidated Health Plans. This brochure provides a general summary of the insurance coverage; the Schedule of Benefits is not all inclusive of eligible benefits payable under this plan. Keep this brochure as no individual policy will be issued. This summary is not a contract; however, the Master Policy will be available for review upon request. The Master Policy contains the contract provisions and shall prevail in the event of any conflict between this brochure and the Master Policy.

Bennington College mandates that all eligible full time Undergraduate and Post Baccalaureate students must enroll in the school sponsored Student Health Insurance Plan or certify that they have Other Valid and Collectible Insurance under another plan. Students with comparable Insurance who do not wish to supplement their insurance may WAIVE out of the Plan.

Home study, correspondence, Internet, and television (TV) courses do not fulfill the Eligibility requirements. The Company maintains its right to investigate eligibility or student status and attendance records to verify that the policy Eligibility requirements have been met. If the Company discovers the Eligibility requirements have not been met, its only obligation is to refund premium, minus any claims paid.

HOW DO I WAIVE?

Eligible students will be automatically enrolled and billed for the Plan unless You waive coverage. To document proof of comparable coverage students need to complete an online waiver form and submit to the college by the deadline dates listed below:

Category	Waiver Deadline Date
Postbaccalaureate Students	**June 12, 2016**
Students enrolling for the Fall Semester	**August 1, 2016**
Students enrolling for the Spring Semester	**February 15, 2017**

To submit the online Waiver Form:

- Go to www.chpstudent.com
- Select Bennington College from drop down box **Click the "Waiver" Tab:**
- Complete all information as directed.

COVERAGE FOR DEPENDENTS

Insured Students who are enrolled in the Student Health Insurance Plan may also enroll their eligible Dependents. Eligible dependents under the plan include the Insured person's spouse, domestic partner, and dependent children under age twenty-six (26). Dependent Eligibility expires concurrently with that of the Insured Student.

Students may also enroll their Dependents within sixty (60) days of an eligible qualifying event. Eligible qualifying events for a Dependent are defined in the Master Policy. Enrollment requests (including payments) received after the sixty (60) days following the qualifying event will not be accepted. Coverage will be effective as of the date of the qualifying event.

EFFECTIVE DATES AND COSTS

The Bennington College Student Health Insurance Plan provides coverage to students for a twelve (12) month period from 12:01 a.m. **August 15, 2016** through **August 14, 2017 and for Early Enrollee Post Baccalaureate students June 1, 2016 through May 31, 2017.**

	Annual* 8/15/16 – 8/14/17	Spring* 2/15/17 - 8/14/17	Post Baccalaureate* 6/1/16 - 5/31/2017
Student	$2,306	$1,144	$2,306
Spouse/Domestic-Civil Union Partner	$2,306	$1,144	$2,306
Each Child	$2,306	$1,144	$2,306
3 or more Children	$6,918	$3,432	$6,918

**All costs above include a fee retained by the Servicing Agent.*

TERMINATION

Coverage will terminate at 11:59 p.m. standard time at the Policyholder's address on the earliest of:

- The Termination Date of the Policy;
- The last day of the term of Coverage for which Premium is paid;
- The date a Covered Person enters full time active military service. Upon written request within 90 days of leaving school, We will refund the unearned pro-rata Premium to such person upon written request;
- The last date of the period for which Premium has been paid following the date a Dependent ceases to be a Dependent as defined.
- The date the Covered Person departs the Policyholder's school for their Home Country. No Benefits will be payable for any medical treatment received in the Covered Person's Home Country.

Termination is subject to the Extension of Benefits provision.

EXTENSION OF BENEFITS

The Coverage provided under this Policy ceases on the Termination Date, shown on the face page. However, if an Insured is:

- Hospital Confined on the Termination Date from a covered Injury or Sickness for which Benefits were paid before the Termination Date, Covered Expenses for such Injury or Sickness will continue to be paid for a period of ninety (90) days or until date of discharge, whichever is earlier.
- Totally Disabled on the Termination Date from a covered Injury or Sickness for which Benefits were paid before the Termination Date, Covered Expenses for such Injury or Sickness will continue to be paid for a period of twelve (12) months or until the date the disability ends, whichever is earlier.

Totally Disabled means, with respect to the Insured, the inability to attend classes at the location where he is enrolled. With respect to a Dependent, or the Insured if such classes are not in session, disability means the inability to engage in any of the usual activities of a person of like age and sex whose health is comparable to that of the Covered Person immediately prior to the Injury or Sickness.

The total payments made in respect of the Insured for such Condition both before and after the termination date will never exceed the Maximum Benefit. After this Extension of Benefits provision has been exhausted, all Benefits cease to exist and under no circumstances will further Benefits be made.

Dependents that are newly acquired during the Insured's Extension of Benefits period are not eligible for Benefits under the provision.

PREMIUM REFUND POLICY

Any Insured Student withdrawing from the college during the first thirty-one (31)

days of the period for which coverage is purchased shall not be covered under the Policy and a full refund of the premium will be made minus any claims. Students withdrawing after thirty-one (31) days will remain covered under the Policy for the full period for which premium has been paid and no refund will be made available. This is true for students on leave for medical or academic reasons, graduating students, and students electing to enroll in a separate comparable plan during the Policy Year. Premiums received by the Company are non-refundable except as specifically provided.

Covered Persons entering the armed forces of any country will not be covered under the Policy as of the date of such entry. A pro-rata refund of premium will be made for such person upon written request received by the Company within ninety (90) days of withdrawal from school. Refunds for any other reason are not available.

PRE-CERTIFICATION PROCESS

The Schedule of Benefits identifies medical Covered Services which must be Pre-Certified by the Review Organization. Advising the Review Organization before You receive such medical Covered Services allows the Review Organization to determine Medical Necessity and Medical Appropriateness. Medical care that is not necessary and appropriate adds to the cost of care and exposes You to unnecessary risk.

You are responsible for calling the Review Organization at the phone number found on the back of Your ID card and starting the Pre-Certification process. For Inpatient services, the call should be made prior to Hospital Confinement. In the case of an Emergency, the call should take place as soon as reasonably possible.

Pre-Certification is not required for Medical Emergency, Urgent Care, or Hospital Confinement for maternity care.

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

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

- For elective *(non-Emergency)* admissions to a Health Care Facility, the Review Organization will notify Your Physician and the Health Care Facility by telephone and/or in writing of the number of Inpatient days, if any, approved;
- For Confinement in a Health Care Facility *longer than* the originally approved number of days, Your treating Physician or the Health Care Facility must contact the Review Organization before the last approved day. The Review Organization will review the request for continued stay to determine Medical Necessity and notify the Physician or the Health Care Facility of its decision in writing or by telephone.

Our Review Organization agent will make this determination within seventy-two (72) hours for an urgent request and four (4) business days for non-urgent

requests following receipt of all necessary information for review. Notice of an adverse determination made by the Review Organization agent will be in writing and will include:

- The reasons for the adverse determination including the clinical rationale, if any.
- Instructions on how to initiate standard or urgent appeal.
- Notice of the availability, upon request of the Covered Person, or the Covered Person's designee, of the clinical review criteria relied upon to make the adverse determination. This notice will specify what, if any additional necessary information must be provided to, or obtained by, the Review Organization Agent in order to render a decision on any requested appeal.

Failure by the Review Organization agent to make a determination within the time periods prescribed shall be deemed to be an adverse determination subject to appeal.

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

SCHEDULE OF BENEFITS

Your Coverage provides for the utilization of Preferred Providers in a Preferred Provider Organization (PPO). The Preferred Provider Organization(s) for your Coverage is: Cigna. Go to www.cigna.com for a list of participating providers.

Actuarial Value: 75.27%

Equivalent or next lowest coverage level: Silver

Please note, while this plan provides an actuarial value of at least 60% in accordance with the Patient Protection and Affordable Care Act, it may not provide an actuarial value on parity with those of the same metal tier currently offered in the health insurance marketplace in your state. The metal tier coverage level noted above indicates the actual or next lowest corresponding metal tier based on the referenced actuarial value of this plan.

Explanation of Reference Number

[1] Must be Pre-Certified

Policy Year Maximum Benefit	In-Network	Out-of-Network
Insured	Unlimited	
Dependent	Unlimited	
Deductible* (except as specified herein) per Policy Year.	$500	$1,000
***Deductible:** • Benefits are subject to Deductible unless otherwise indicated. • The Deductible shall not apply: ○ to In-Network Preventive/wellness exams and immunizations ○ to Outpatient Prescription Drugs ○ Copayments do not apply to deductible		
Insured percent (except as specifed herein)**.** The Insured Percent may vary at the SHC, as specified herein.	75% of the Preferred Allowance (PA)	50% of Reasonable and Customary Charges (R&C)
Student Health Center	100% of Charges	
Medical Out-of-Pocket Maximum**		
Covered Person	$6,850	None
Family	$13,700	None
****Out-of-Pocket Maximum:** ○ Includes the Prescription Drug Out-of-Pocket Maximum ○ Includes Coinsurance, Copayments and Deductibles; ○ Excludes Out-of-Network; non-covered medical expenses and Elective treatment; ○ Any Coinsurance paid by You is applied to the Out-of-Pocket Limit per Policy Year; ○ Once the Out-of-Pocket Limit is reached by the Covered Person, the Insured Percent paid by the Company will increase to 100% In-Network up to the Maximum Benefit as specified herein.		
Prescription Drug Out-of-Pocket Maximum (including Copayment, Coinsurance and Deductible) per Covered Person	$1,300 single/ $2,600 family	N/A
Covered Charges – Essential Health Benefits	**In-Network Benefit**	**Out-of-Network Benefit**

Preventive Care (See Definition for additional information)		
Wellness, Preventive and Immunization Services	100% of PA Deductible and Copayment waived	50% of R&C
Office visits - performed and billed by a Physician's office, including Family or General Practice, Nurse, Physician Assistant, Pediatrician, Internal Medicine or OB/GYN when acting as a primary care Physician. Limited to one (1) visit per day and does not apply when related to surgery or Physical Therapy. Includes Telemedicine when Medically Necessary	75% of PA after a $40 Copayment per visit	50% of R&C after a $40 Copayment per visit
Specialist visits	75% of PA after a $40 Copayment per visit	50% of R&C after a $40 Copayment per visit
Consulting Physician - Limited to one (1) visit per day and does not apply when related to surgery or Physical Therapy.	75% of PA after a $40 Copayment per visit	50% of R&C after a $40 Copayment per visit
Diagnostic Imaging - Includes x-ray services which are diagnostic or therapeutic.	75% of PA	50% of R&C
Laboratory Services - Includes laboratory services which are diagnostic or therapeutic.	75% of PA	50% of R&C
CT Scan, MRI, and /or PET Scans	75% of PA	50% of R&C
Infusions (done in an Outpatient Health Care Facility or Physician's office)	75% of PA	50% of R&C
Injections (done in an Outpatient Health Care Facility or Physician's office)	75% of PA	50% of R&C

Radiation	75% of PA	50% of R&C
Chemotherapy	75% of PA	50% of R&C
Dialysis (hemodialysis and peritoneal) and Filtration Procedures, for acute or chronic renal failure - Includes administration and supplies.	75% of PA	50% of R&C
Inpatient Services [1] – (other than Surgery and Maternity)		
Miscellaneous Hospital Services Includes meals and prescribed diets, Diagnostic Imaging, Laboratory, pharmaceuticals administered while an Inpatient, use of operating room, anesthesia, therapeutic services, supplies, dressings, blood and blood plasma, oxygen, radiation therapy, chemotherapy, miscellaneous items used in association with a surgical event, Pre-Admission Testing and Inpatient Rehabilitation.	75% of PA	50% of R&C
Room and Board expense, at the semi-private room and general nursing care provided by the hospital NOTE: Only one (1) copayment amount for Room and Board applies to each admission for the same Condition.	75% of PA after $150 Co-pay per admission	50% of R&C after $150 Co-pay per admission
Intensive Care Room **NOTE:** Only one (1) Copayment amount for Room and Board applies to each admission for the same Condition.	75% of PA	50% of R&C
Physician visits, during Confinement in a hospital. Limited to one (1) visit per day and does not apply when related to surgery.	75% of PA	50% of R&C
Consulting Physician, when requested and approved by the Attending Physician. Limited to one (1) visit per Consulting Physician per day	75% of PA	50% of R&C

Skilled Nursing Facility and Sub-Acute Care Facility [1] - Includes semi-private room and board, general nursing services, meals and prescribed diets, supplies, Diagnostic Imaging, laboratory, Rehabilitation and Physician visits.	75% of PA	50% of R&C
Inpatient Rehabilitation Facility [1] - Includes Physical Therapy, occupational therapy, Restorative Speech Therapy, cardiac therapy, and pulmonary therapy which is expected to result in significant return of function.	75% of PA	50% of R&C
Surgical Services		
When multiple surgeries are performed through the same incision at the same operative session, We will pay an amount not to exceed the Benefit for the most expensive procedure being performed. When multiple surgeries are performed through more than one (1) incision at the same operative session, We will pay an amount not to exceed the Benefit for the most expensive procedure being performed and 50% of the Benefit otherwise payable for each subsequent procedure.		
Inpatient Surgical Services [1]		
Surgeon	75% of PA	50% of R&C
Assistant Surgeon	75% of PA	50% of R&C
Anesthetist Services	75% of PA	50% of R&C
Inpatient Surgical Miscellaneous - includes supplies, drugs, facility fee, and miscellaneous items used in association with the surgical event.	75% of PA	50% of R&C
Outpatient Surgical Services		
Surgeon	75% of PA	50% of R&C
Assistant Surgeon	75% of PA	50% of R&C
Anesthetist Services	75% of PA	50% of R&C
Outpatient Surgical/Day Surgery Miscellaneous - Includes supplies, drugs, facility fee, anesthesia, Diagnostic Imaging, laboratory and miscellaneous items used in association with the surgical event.	75% of PA	50% of R&C

Other Surgical Services		
General Anesthesia for Dental services	75% of PA	50% of R&C
Reconstructive Surgery	75% of PA	50% of R&C
Organ Transplant Surgery [1] ***Live Donor***: Coverage is provided when using a live donor (includes surgical expenses, storage and transportation of the organ for each covered transplant procedure completed. Costs must be incurred within one hundred twenty (120) days from the date of the donor's surgery. ***Deceased Donor:*** Coverage is provided when using a deceased donor, per solid organ transplant for search, removal, storage, and transportation of the organ. ***Transplant Recipient:*** From thirty (30) days before the transplant to three hundred sixty-five (365) days after a bone marrow transplant OR from five (5) days before the transplant to three hundred sixty-five (365) days after the transplant. Coverage for the recipient in a transplant operation shall also provide reimbursement of any medical expenses of a live donor to the extent that benefits remain and are available under the recipient's policy, after benefits for the recipient's own expenses have been paid. Limited to one (1).	75% of PA	50% of R&C

Obesity Surgery [1] Limited to one (1) bariatric procedure per Lifetime.	75% of PA	50% of R&C
TMJ - surgery of the jaw to correct or treat TMJ (the dysfunction of the temporomandibular joints).	75% of PA	50% of R&C
Reproductive Services		
Voluntary Sterilization Surgery **Note:** Sterilization procedures for women are covered under Preventive Care.	75% of PA	50% of R&C
Sterilization reversal - Limited to one (1) procedure per lifetime	75% of PA	50% of R&C
Maternity Care – Includes forty-eight (48) hours of Inpatient care following a normal delivery and ninety-six (96) hours of Inpatient care following a cesarean delivery, unless after conferring with the mother or a person responsible for the mother or newborn, the Attending Physician or a certified nurse-midwife who consults with a Physician, decides to discharge the mother or newborn child sooner. In the event of early discharge, Home Health Care visits will be provided		
Pre and post-natal services, including diagnostic services performed and billed by a Physician's office, delivery and Inpatient Physician visits for mother and baby.	Paid the same as any other Sickness	
Hospital services - Includes room and board, general nursing care, meals and prescribed diets, pharmaceuticals administered while an Inpatient, anesthesia, dressings, other miscellaneous items, rooming in for maternity care, delivery, routine newborn care, including circumcision, or sick newborn care.	Paid the same as any other Sickness	

Diagnostic services performed and billed by a Physician's office, including ultrasounds and amniocentesis.	Paid the same as any other Sickness	
Mental Conditions and Alcoholism/Drug Abuse		
Inpatient services [1] - Includes Alcoholism/Drug detoxification and residential treatment programs.	Paid the same as any other Sickness	
Outpatient Office Visits – Includes detoxification in outpatient rehabilitation facility (including services for the Covered Person's family when necessary); Includes partial residential or day treatment.	Paid the same as any other Sickness	
Testing and treatment for learning disabilities, Attention Deficit Disorder, Attention Deficit Hyperactivity Disorder, and all related charges	Paid the same as any other Sickness	
Urgent Care and Emergency Services		
Urgent Care Facility Services	75% of PA after a $75 copayment per visit	50% of R&C after a $75 copayment per visit
Emergency services – visits to an Emergency room for stabilization or the initiation of treatment for an Emergency Condition. Includes Physician's fees, Diagnostic Imaging, Laboratory, Injections, use of emergency room and supplies, and facility charges. **Note:** The Copayment amount for this visit is waived if You are admitted to a Hospital for the same Condition within forty-eight (48) hours of the visit	75% of PA After a $150 Co-pay per visit	75% of PA After a $150 Co-pay per visit

Emergency Medical Transportation services	75% of PA	75% of R&C
Other Services		
Allergy Testing	75% of PA after a $40 copayment per visit	50% of R&C after a $40 copayment per visit
Allergy Injections/treatment - Includes treatment of anaphylaxis and angioedema, severe chronic sinusitis not responsive to medications and asthma not responding to usual treatments. Also includes the administration of allergy therapy, injections, allergy serum, and supplies used for allergy therapy.	75% of PA After a $40 Co-pay per visit	50% of R&C After a $40 Co-pay per visit
Habilitative Care - only when prescribed by the Attending Physician; Includes Outpatient Physical Therapy, occupational therapy and Speech Therapy for a function that did not previously exist, but would normally be expected to exist.	75% of PA after a $40 copayment per visit	50% of R&C after a $40 copayment per visit
Rehabilitative Care - only when prescribed by the Attending Physician; Includes Outpatient Physical Therapy, occupational therapy, Restorative Speech Therapy, which is expected to result in significant return of function.	75% of PA after a $40 copayment per visit	50% of R&C after a $40 copayment per visit
Pulmonary Therapy - Maximum of thirty-six (36) visits and limited to three (3) visits per week	75% of PA	50% of R&C
Cardiac Therapy - Maximum of thirty-six (36) visits for each new cardiac event and limited to three (3) visits per week	75% of PA	50% of R&C

Respiratory Therapy	75% of PA	50% of R&C
Chiropractic Care - Includes x-rays, office visits, laboratory services, manipulations and modalities (e.g., hot packs, cold packs and ultrasounds, etc.), regardless of Provider type.	75% of PA	50% of R&C
Dermatology only when prescribed by the Attending Physician	75% of PA	50% of R&C
Podiatry only when prescribed by the Attending Physician	75% of PA	50% of R&C
Home Health Care	75% of PA	50% of R&C
Hospice – includes up to six (6) family social services visits before the patient's death and up to two (2) bereavement visits following the patient's death.	75% of PA	50% of R&C
Diabetic treatment and Education	Paid the same as any other Sickness	
Nutritional Counseling – Limited to three (3) outpatient visits per Policy Year (Visits for treatment of diabetes do not count toward this visit limit.)	75% of PA	50% of R&C
Prosthetic and Orthotic Device - Includes replacement, repair, fitting and adjustment.	75% of PA	50% of R&C
Durable Medical Equipment (DME) - Includes replacement, repair, fitting and adjustment.).	75% of PA	50% of R&C
Neuropsychological Testing	75% of PA	50% of R&C
Dental treatment due to Injury to a Sound Natural Tooth not including broken fillings or damage caused by biting or chewing Treatment must begin within six (6) months of Injury	100% of R&C up to $1,000; 50% thereafter	

Dental surgery to correct gross deformity resulting from major disease or surgery. Surgery must take place within six (6) months of the onset of the disease or within six (6) months of surgery.	75% of PA	50% of R&C
Dental Prosthetics for treatment of accidental Injury	50% of R&C	
Outpatient private duty nursing care	75% of PA	50% of R&C
First pair of eyeglasses or contact lenses after surgery when the lens was not replaced at the time of surgery	75% of PA	50% of R&C
Optometrist services when a disease condition is suspected and the optometrist refers you to a Physician.	75% of PA	50% of R&C
Preventive Dental & Vision for Covered Persons under age twenty-one (21)		
Preventive Dental – preventive & diagnostic services, for Covered Persons under age twenty-one (21). Limited to 2 exams / prophylaxis / topical fluoride treatments per Policy Year. Includes: • x-rays – bitewing, full-mouth, and panoramic – 1 per 6 months • sealants (as needed for permanent 1st and 2nd molars only, 1 per tooth every 60 months) • space maintainers – 1 per 24 months full mouth debridement – 1 per 24 months; counts toward prophylaxis benefit when performed	100% of R&C	

Pediatric Dental – basic restorative services, for Covered Persons under age twenty-one (21). Includes: • emergency palliative treatment of pain • fillings (amalgam, resin-based composite) – limited to 1 per tooth per year • prefabricated stainless steel crown • periodontal maintenance • simple extractions & oral surgery • denture repair – 1 per denture per 6 months • endodontics – pulpal therapy (1 per tooth per lifetime), apicoectomies, retrograde fillings, and root canal therapy (permanent teeth only; 1 per tooth per lifetime) general anesthesia, IV sedation, and non-IV conscious sedation – in conjunction with other covered services, as Medically Necessary	70% of R&C
Pediatric Dental – major services, for Covered Persons under age twenty-one (21). Includes: • prosthodontics - crowns, bridges, and dentures - 1 per tooth/arch every 60 months crown repair	50% of R&C
Pediatric Dental – Medically Necessary orthodontia services *, for Covered Persons under age twenty-one (21). *Requires pre-authorization	50% of R&C

Routine Vision Exam for Covered Persons under age twenty-one (21). Includes prescription eyeglasses (lenses and frames), or one (1) year supply of contact lenses in lieu of eyeglasses, limited to once per Policy Year; Limited to 1 exam/fitting per Policy Year.	100% of R&C up to $150, 50% thereafter
Outpatient Prescription Drugs	**Pharmacy Benefit**

Retail Prescription Drugs - per prescription or refill, subject to dispensing limits. The Pharmacy Benefits Manager (PBM) is: Cigna.

Note: Retail Prescription Drugs will be considered an Essential Health Service unless prescribed drug is related to an Elective Treatment, subject to exclusions and other limitations of the Policy.

4 Tier Plan	In-Network Pharmacy 100% after a:	Out-of-Network Pharmacy
Generic Drugs	$20 Copayment	Not covered
Formulary Brand Drugs	$40 Copayment	Not covered
Non-Formulary Brand Drugs	$60 Copayment	Not covered
Specialty and Injectable Drugs	$60 Copayment	Not covered

You must show Your Identification Card to the pharmacist. Normally there are no claims to file. If You forget Your Identification Card, You may be asked to file a claim form for reimbursement. Save Your receipt and call Our customer service department to request a form. You will be notified of any changes in prescription coverage and can access the preferred drug list at www.chpstudent.com.

- Only a thirty (30) day supply can be dispensed at any time (certain exceptions apply as specified by the retail pharmacy).
- One (1) Copayment per thirty (30) day supply;
- Includes prescription contraceptives which have been approved by the FDA prescribed pre-natal vitamins and smoking deterrent prescription medications.
- Includes medications, equipment and supplies for the management and treatment of diabetes
- ADD and ADHD-related drugs are covered;
- The Deductible does not apply.
- The Covered Person will be charged for the difference between Brand and Generic the Tier 2, 3 Copayment for a Brand drug when there is a Generic equivalent available unless "Do Not Substitute" or "Dispense as Written" is indicated on the prescription.

Infertility drugs are limited to a one hundred twenty (120) day supply per Policy Year. Attempt to conceive must be through natural means (not by artificial insemination, in vitro fertilization, embryo transplantation and gamete intrafallopian transfer, zygote intrafallopian transfer or any variations of these procedures). You must get Prior Approval for the fertility medications.

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State Mandated Benefit (See Policy Section for Details)	
Covered Charge	
Athletic trainer	Paid the same as any other Physician
Autism Spectrum Disorders (birth to age twenty-one (21))	See above in the Schedule of Benefits for cost sharing information
Cancer Clinical Trial	Paid as any other Condition
Chemotherapy treatment	Paid as any other Condition
Chiropractic coverage	See above in the Schedule of Benefits for cost sharing information
Colorectal screening	Paid under Preventive Services
General Anesthesia for Certain Dental Procedures	See above in the Schedule of Benefits for cost sharing information
Home Health Services (maternity & childbirth)	See above in the Schedule of Benefits for cost sharing information
Low Protein Modified Food Products	Paid as any other Condition
Mammography	Paid under Preventive Services
Maternity	See above in the Schedule of Benefits for cost sharing information
Mental Health (including alcohol/drug abuse)	See above in the Schedule of Benefits for cost sharing information
Midwife and Home Birth Coverage	Paid the same as any other Provider
Naturopathic Physician	Paid the same as any other Physician
Off-label Drugs for cancer treatment	Paid as any other Prescription drug
Organ transplant surgery	See above in the Schedule of Benefits for cost sharing information
Outpatient Diabetes treatment	Paid as any other Condition

Pediatric vaccines	Paid under Preventive Services	
Prescriptions bought in Canada	Paid as any other Prescription drug	
Prostate screening	Paid as any other Condition	
Prosthetic devices	Paid as any other Condition	
Telemedicine	Paid as any other Provider	
Tobacco Cessation Program (Prescribed medication for tobacco cessation would be covered at 100%)	See above in the Schedule of Benefits for cost sharing information	
ELECTIVE TREATMENT		
Covered Charge PLEASE NOTE: ALL BENEFITS ARE PER POLICY YEAR UNLESS OTHERWISE NOTED.	**In-Network Benefit**	**Out-of-Network Benefit**
Elective Treatment		
Non Emergency treatment outside the United States	60% of R&C	
Medical Evacuation/Repatriation	100% of Charges	
Family Travel Benefit - up to $5,000 per Policy Year	100% of Charges	

PREFERRED PROVIDER INFORMATION

By enrolling in this Insurance Program, you have the Cigna PPO Network of Participating Providers, providing access to quality health care at discounted fees. To find a complete listing of Cigna PPO Network of Participating Providers, go to www.cigna.com, or contact Consolidated Health Plans at (413) 733-4540, toll-free at (800) 633-7867, or www.chpstudent.com for assistance.

"Preferred Providers" are the Physicians, Hospitals and other health care providers who have contracted to provide specific medical care at negotiated prices.

If care is received within the Network from a Preferred Provider, all Covered Medical Expenses will be paid at the Preferred Provider level of benefits found on the Schedule of Benefits. In the case of an Emergency, if an Out-of-Network Provider is used, the In-Network percentage in the Schedule of Benefits will be applied.

A Covered Person is not required to seek treatment from a Preferred Provider. Each Covered Person is free to elect the services of a Provider and Benefits payable will be made in accordance with the terms and Conditions of this benefit.

"Preferred Allowance" means the amount a Preferred Provider will accept as payment in full for Covered Medical Expenses.

"Out-of-Network" providers have not agreed to any prearranged fee schedules. Insured's may incur significant out-of-pocket expenses with these providers. Charges in excess of the insurance payment are the Insured's responsibility.

COORDINATION OF BENEFITS

The Policy Year is the basis for consideration of claims. This provision will be used when the Benefits the Covered Person would receive under this Policy plus those received under all other Plans would exceed the total Allowable expense. If the Benefits provided under all Plans exceed the Allowable expense, We will reduce Our Benefits so that the total benefit received from all plans does not exceed 100% of Allowable expenses. When Benefits are reduced under the primary plan because the Covered Person did not comply with the plan provisions, the amount of such reduction will not be considered an Allowable expense.

SUBROGATION AND RECOVERY RIGHTS

If We pay Covered Expenses for an Accident or Injury You incur as a result of any act or omission of a third party, You are obligated to reimburse Us for the expenses paid. We may also take subrogation action directly against the third party. Our reimbursement rights are limited by the amount You recover. Our reimbursement and subrogation rights are subject to deduction for the pro-rata share of Your costs, disbursements and reasonable attorney fees. You must cooperate with and assist Us in exercising Our rights under this provision and do nothing to prejudice Our rights.

EXCLUSIONS

Unless specifically included, no Benefits will be paid for: a) Loss or expense caused by, contributed to, or resulting from; b) treatment, services, or supplies for, at, or related to:

1. Eyeglasses, contact lenses, (except as provided herein) routine eye refractions, eye examinations except as in the case of Injury, prescriptions or fitting of eyeglasses or contact lenses, vision correction surgery or Orthoptic Therapy, visual training or radial keratotomy or similar surgical procedures to correct vision, except as provided herein or when due to a disease process or eye refractions performed by a Physician or optometrist, when used as a diagnostic tool in conjunction with a chronic or acute medical Condition.

2. Hearing Screenings (except as specifically provided in the Policy) or hearing examinations or hearing aids and the fitting or repairingreplacement of hearing aids, except as specifically stated and except in the case of Accident or Injury.
3. Vaccines and immunizations (except as specifically provided in the Policy): a) required for travel; and b) required for employment. Treatment (other than surgery) of chronic Conditions of the foot including weak feet, fallen arches, flat foot, chronic foot strain, care of corns, calluses, or symptomatic complaints of the feet; any type of massage procedure on or to the foot, corrective shoes, shoe inserts except when attached to a brace; except for treatment of Injury, infection or disease or except as provided herein.
4. Cosmetic treatment/cosmetic surgery or plastic surgery, resulting complications, consequences and after effects or other services and supplies furnished primarily to improve appearance rather than a physical function or control of organic disease, except as provided herein or for treatment of an Injury that is covered under the Policy. Improvements of physical function does not include improvement of self-esteem, personal concept of body image, or relief of social, emotional, or psychological distress. Procedures not covered include, but are not limited to: face lifts; sagging eyelids; prominent ears; skin scars; warts, non-malignant moles and lesions; hair growth hair removal; correction of breast size, asymmetry or shape by means of reduction, augmentation, or breast implants (except for correction or deformity resulting from mastectomies or lymph node dissections); lipectomy services and supplies related to surgical suction assisted lipectomy; rhinoplasty; nasal and sinus surgery; and deviated nasal septum, including submucous resection, except when Medically Necessary for treatment of acute purulent sinusitis. This exclusion does not include Reconstructive Surgery when the service is incidental to or follows surgery resulting from trauma, Injury, infection or other diseases of the involved part, or reconstructive surgery because of congenital disease or anomaly of a covered Dependent child which has resulted in a functional defect.
5. Treatment, service, or supply which is not Medically Necessary for the diagnosis, care or treatment of the Sickness or Injury involved.
6. Treatments which are considered to be unsafe, Experimental, or Investigational by the American Medical Association (AMA), and resulting complications, except to the extent required by law for routine costs for Covered Persons who participate in approved cancer clinical trials.

7. Custodial Care; Care provided in a: rest home, home for the aged, halfway house, health resort, college infirmary or any similar facility for domiciliary or Custodial Care, (except as provided for Hospice care).
8. Dental care or treatment of the teeth, gums or structures directly supporting the teeth, including surgical extractions of teeth, (except as specified herein).
9. Injury sustained by reason of a motor vehicle Accident to the extent that Benefits are paid or payable motor vehicle no-fault law whether or not claim is made for such Benefits or if the Insured is not properly licensed to operate the motor vehicle within the jurisdiction in which the Accident takes place. This exclusion will not apply to passengers if they are insured under the Policy.
10. Injury occurring in consequence of riding as a passenger or otherwise being in any vehicle or device of aerial navigation, except as a fare-paying passenger on a regularly scheduled flight of a commercial airline. This exclusion does not apply to Insured's while taking flight instruction for college credit.
11. Reproductive/Infertility services, including but not limited to: treatment of infertility (male or female) including diagnosis, diagnostic tests, medication, surgery, supplies, and fertilization procedures rendered for the purpose or with the intent of inducing conception; premarital examination; impotence, organic or otherwise; sterilization (except as specifically provided in the Policy) and sterilization reversal (following first attempt); except as specifically provided in this Policy. Examples of fertilization procedures are ovulation induction procedures, in vitro fertilization, artificial insemination, embryo transfer or similar procedures that augment or enhance Your reproductive ability.
12. More than one (1) attempt at sterilization reversal (vasectomy reversal, vasovasostomy, vasovasorrhapy, tubal ligation reversal, tubotubal anastomosis)
13. Elective termination of pregnancy except to preserve the life of the female upon whom the abortion is performed.
14. Services provided normally without charge by the health service of the Policyholder or services covered or provided by a student health fee; Services rendered by employees or Physicians or other persons or retained by the University or for the use of the Universities facilities.
15. Treatment in a government Hospital, unless there is a legal obligation for the Covered Person to pay for such treatment.
16. Expenses that would be payable, or medical treatment that is available, under any governmental or national health plan for which the Covered Person could be eligible, except Medicaid.

17. Any services of a Physician or Nurse who lives with You or Your Dependent(s) or who is related to You or Your Dependent(s) by blood or marriage.
18. Services received after the Covered Person's Coverage ends, except as specifically provided under the Extension of Benefits provision.
19. Services for the treatment of any Injury or Sickness incurred while the Covered Person was committing or attempting to commit a felony; or while taking part in an insurrection or riot.
20. Injury or Sickness for which Benefits are paid or payable under any state or federal; workers' compensation, employer's liability, or occupation disease law or act, or similar legislation.
21. War or any act of war, declared or undeclared; or any Injury or Sickness arising out of service in the armed forces or units auxiliary of any country.
22. Modifications made to dwellings, property, or automobiles such as ramps, elevators, stair lifts, swimming pools, spas, air conditioners or air-filtering systems, equipment that may increase the value of the residence, or car hand controls, whether or not their installation is for purpose of providing therapy or easy access, or are portable to other locations. .
23. Acupuncture and biofeedback, unless Medically Necessary as performed within the scope of a naturopathic Provider's license.
24. Diagnosis and treatment of sleep disorders including but not limited to apnea monitoring, sleep studies, and oral appliances used for snoring. except treatment and appliances for documented obstructive sleep apnea.
25. Elective surgery or treatment.
26. Long term care facility.

DEFINITIONS

The terms listed below, if used, have the meaning stated.

Accidental Injury: A specific unforeseen event, which directly, and from no other cause, results in an Injury.

Coinsurance: The percentage of the expense for which the Covered Person is responsible for a Covered Service. The Coinsurance is separate and not a part of the Deductible and Copayment

Copayment: A specified dollar amount a Covered Person must pay for specified Covered Charges. The Copayment is separate from and not a part of the Deductible or Coinsurance.

Covered Charge(s) or Covered Expense: As used herein means those charges for any treatment, services or supplies:

- for Preferred Providers, not in excess of the Preferred Allowance;

- for Out-of-Network Providers not in excess of the Reasonable and Customary expense;
- not in excess of the charges that would have been made in the absence of this insurance;
- not otherwise excluded under this Policy; and
- incurred while this Policy is in force as to the Covered Person.

Covered Person: A person:

- who is eligible for Coverage as the Insured or as a Dependent;
- who has been accepted for Coverage or has been automatically added;
- for whom the required Premium has been paid; and
- whose Coverage has become effective and has not terminated.

Deductible: The amount of expenses for Covered Services and supplies which must be incurred by the Covered Person before specified Benefits become payable.

Dependent: A person who is the Insured's:

- Legally married spouse, who is not legally separated from the Insured and resides with the Insured.
- Domestic/Civil Union Partner who resides with the Insured.
- Child who is under the age of twenty-six (26).

The term child refers to the Insured's:

- Natural child or child of Domestic/Civil Union Partner;
- Stepchild or foster child; A stepchild is a Dependent on the date the Insured marries the child's parent.
- Adopted child, including a child placed with the Insured for the purpose of adoption, from the moment of placement as certified by the agency making the placement.
- Foster child is a Dependent from the moment of placement with the Insured as certified by the agency making the placement.

Domestic/Civil Union Partner: Two (2) individuals who, together, each meet all of the following criteria set forth below:

1. Are eighteen (18) years of age or older.
2. Are competent to enter into a contract.
3. Are not legally married to, nor the Domestic/Civil Union Partner of, any other person.
4. Are not related by marriage.
5. Are not related by blood closer than permitted under marriage laws of the state in which they reside.
6. Have entered into the Domestic/Civil Union Partner relationship voluntarily, willingly, and without reservation.

7. Have entered into a relationship which is the functional equivalent of a marriage, and which includes joint responsibility for each other's basic living expenses
8. Have been living together as a couple for at least six (6) months prior to obtaining the Coverage provided under this Policy and the Certificate.
9. Intend to continue the Domestic/Civil Union Partner relationship indefinitely, while understanding that the relationship is terminable at the will of either partner. A copy of the signed affidavit may be required upon enrollment.

Elective Treatment: Those services that do not fall under the definition of Essential Health Benefits. Medical treatment which is not necessitated by a pathological change in the function or structure in any part of the body occurring after the Covered Person's Effective Date of Coverage. Elective benefits is shown in the Schedule of Benefits, as applicable.

Emergency: An Illness, Sickness or Injury for which immediate medical treatment is sought at the nearest available facility. The Condition must be one which manifests itself by acute symptoms which are sufficiently severe that a reasonable person would seek care right away to avoid severe harm. Emergency does not include the recurring symptoms of a chronic Condition unless the onset of such symptoms could reasonably be expected to result in the above listed complications.

Essential Health Benefits: Has the meaning found in section 1302(b) of the Patient Protection and Affordable Care Act and as further defined by the Secretary of the United States Department of Health and Human Services, and includes the following categories of Covered Services: ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care (in accordance with the applicable state or federal benchmark plan).

Habilitative Treatment or Therapy: Treatment or therapy that develops or attempts to develop a function that did not previously exist, but would normally be expected to exist. Treatment or therapy is considered habilitative if the function has achieved maximal or optimal improvement or is static, showing no progressive improvement with additional treatment.

Injury: Bodily Injury due to a sudden, unforeseeable, external event which results independently of disease, bodily infirmity or any other causes. All injuries sustained in any one (1) Accident, including all related conditions and recurrent symptoms of these injuries, and are considered a single Injury.

Insured Percent: That part of the Covered Charge that is payable by the Company after the Deductible and/or Copayment has been paid.

Medically Necessary/Medical Necessity: Refer to the Medically Necessity provisions of the Policy.

Out-of-Pocket Maximum: The most You pay during a Policy Year before your Coverage begins to pay 100% of the allowed amount. This limit will never include Premium, balanced billed charges or health care Your Policy does not cover. Your Out-of-Network payments or other expenses and Elective treatment do not count towards this limit.

Physician: A health care professional practicing within the scope of his or her license and is duly licensed by the appropriate State Regulatory Agency to perform a particular service which is covered under the Policy, and who is not:

1. The Insured Person;
2. A Family Member of the Insured Person; or
3. A person employed or retained by the Policyholder.

Preferred Allowance (PA): The amount a Preferred Provider has agreed to accept as payment in full for Covered Charges.

Preferred Providers: Physicians, Hospitals and other healthcare Providers who have contracted to provide specific medical care at negotiated prices. See the definition of In-Network Benefit.

Preferred Provider Organization or PPO: The entity named in the Schedule of Benefits.

Preventive Care: Provides for periodic health evaluations, immunizations and laboratory services in connection with periodic health evaluations, as specified in the Schedule of Benefits. Well Baby and Child Care, and Well Adult Care benefits will be considered based on the following:

a) Evidenced-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force, except that the current recommendations of the United States Preventive Service Task Force regarding breast cancer screening, mammography, and prevention of breast cancer shall be considered the most current other than those issued in or around November 2009;
b) Immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved;
c) With respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration; and

d) With respect to women, such additional preventive care and screenings, not described in paragraph (a) above, as provided for in comprehensive guidelines supported by the Health Resources and Services Administration.

Reasonable and Customary (R&C): The most common charge for similar professional services, drugs, procedures, devices, supplies or treatment within the area in which the charge is incurred. The most common charge means the lesser of:

- The actual amount charged by the Provider;
- The negotiated rate, if any; or
- The fee often charged for in the geographical area where the service was performed.

The Reasonable Charge is determined by comparing charges for similar services to a national database adjusted to the geographical area where the services or procedures are performed, by reference to the 80th percentile of Fair Health Inc. schedules. The Insured Person may be responsible for the difference between the Reasonable Charge and the actual charge from the Provider. For a Provider who has a reimbursement agreement, the Reasonable Charge is equal to the Preferred Allowance under any reimbursement agreement with Us, either directly or indirectly through a third party, as described in the Preferred Provider Benefit provision. If a Provider accepts as full payment an amount less than the rate negotiated under the reimbursement agreement, the lesser amount will be the maximum Reasonable Charge.

Sickness: Illness, disease or condition, including pregnancy and Complications of Pregnancy that impairs a Covered Person's normal functioning of mind or body and which is not the direct result of an Injury or Accident. All related conditions and recurrent symptoms of the same or a similar condition will be considered the same Sickness.

We, Our and Us: Nationwide Life Insurance Company.

You and Your: The Covered Person or Eligible Person as applicable.

Male pronouns whenever used include female pronouns

MEDICAL EVACUATION BENEFIT

If the Insured cannot continue his academic program because he sustains an Accidental Injury or Emergency Sickness while Insured under the Policy or if a Covered Dependent sustains an Accidental Injury or Emergency Sickness and is more than a 100 mile radius from his current place of primary residence or outside of his Home Country, We will pay for the actual charge, no cost sharing, incurred for an emergency medical evacuation of the Covered Person to or back to the Insured's home state, country, or country of regular domicile. No payment will be made under this provision unless the evacuation follows a Hospital

Confinement of at least five (5) consecutive days. Before We make any payment, We require written certification by the Attending Physician that the evacuation is necessary. Any expense for medical evacuation requires Our prior approval and coordination. For international students, once evacuation is made outside the country, Coverage terminates. This Benefit does not include the transportation expense of anyone accompanying the Covered Person or visitation expenses.

REPATRIATION OF REMAINS BENEFIT

If the Covered Person dies while Insured under the Policy and is more than 100 miles from his permanent residence or outside of his Home Country, We will pay for the actual charge no cost sharing, incurred for embalming, and/or cremation and returning the body to his place of permanent residence in his home state, country or country of regular domicile. Expenses for repatriation of remains require the Policyholder's and Our prior approval. If You are a United States citizen, Your Home Country is the United States. This Benefit does not include the transportation expense of anyone accompanying the body, visitation or lodging expenses or funeral expenses.

FAMILY TRAVEL BENEFIT

If the Insured is Hospital Confined due to an Accidental Injury or Emergency Sickness for more than five (5) consecutive days, is likely to be hospitalized for more than five (5) days or is in critical condition, We will pay for expenses reasonably Incurred:

1. To bring one (1) person designated by the Insured to and from the Hospital or other medical facility where the Insured is Confined if the Insured is alone and if the place of Confinement is outside a 100 mile radius from the Insured's primary place of residence. Expenses will be limited to the cost for one economy round-trip airfare ticket to, and the hotel accommodations in the place of the Hospital Confinement. Payment for meals, ground transportation and other incidentals are the responsibility of the Family Member or friend. With respect to any one (1) trip, this benefit is payable only once for that trip, regardless of the number of Covered Persons on that trip. No more than one (1) visit may be made during any twelve (12) month period. No benefits are payable unless the trip is approved in advance by the Administrator.
2. To return to their current place of primary residence, with an attendant if necessary, any of the Insured's Children who were accompanying the Insured when the Injury or Emergency Sickness occurred. The determination of whether the Insured Person will be hospitalized for

more than five (5) days or is in critical condition shall be made by Us after consultation with the attending Physician.

All transportation arrangements made must be by the most direct and economical conveyance and route possible.

CLAIM PROCEDURES

In the event of an Injury or Sickness the Insured Person should:

1. Report to their Physician, Hospital or Student Health Center.
2. Mail to the address below all medical and hospital bills along with the patient's name and insured student's name, address, Social Security number or student ID number and name of the University under which the student is insured. A Company claim form is not required for filing a claim.
3. File claim within ninety (90) days of Injury or first treatment for a Sickness. Bills should be received by the Company within ninety (90) days of service. Bills submitted after one year will not be considered for payment except in the absence of legal capacity.

Itemized medical bills should be mailed promptly to Cigna at the address listed.

SUBMIT ALL CLAIMS TO:
Cigna
PO Box 188061
Chattanooga, TN 37422-8061
Electronic Payor ID: 62308

Direct all questions regarding benefits available under the Plan, claim procedures, status of a submitted claim or payment of a claim to Consolidated Health Plans.

Claims Administrator:
CONSOLIDATED HEALTH PLANS
2077 Roosevelt Avenue
Springfield, MA 01104
(413) 733-4540 or Toll Free (800) 633-7867
www.chpstudent.com
Group Number: S210814

CLAIMS APPEAL PROCESS

Once a claim is processed and upon receipt of an Explanation of Benefits (EOB), an Insured Person who disagrees with how a claim was processed may appeal that decision. The Insured Person must request an appeal in writing within 180 days of the date appearing on the EOB. The appeal request must include any additional information to support the request for appeal, e.g. medical records,

physician records, etc. Please submit all requests to the Claims Administrator at the address below.

Claims Administrator:
CONSOLIDATED HEALTH PLANS
2077 Roosevelt Avenue
Springfield, MA 01104
www.chpstudent.com
(413) 733-4540

Servicing Agent:
Wills Insurance Company
116 South Street
Bennington, VT 05201
802-442-5414
dnewell@willsinsurance.com

This plan is underwritten by and offered by:
NATIONWIDE LIFE INSURANCE COMPANY
Columbus, OH
Policy Number: 302-055-4414

For a copy of the privacy notice you may go to:
www.consolidatedhealthplan.com/about/hipaa

VALUE ADDED SERVICES

The following services are not part of the Plan Underwritten by Nationwide Life Insurance. These value added options are provided by Consolidated Health Plans.

Davis VISION DISCOUNT PROGRAM

For Vision Discount Benefits please go to:
www.chpstudent.com

Your out-of-pocket costs may be lower when you utilize the Cigna PPO Network of Participating Providers. For a listing of Cigna PPO Network Participating Providers, go to www.cigna.com or contact Consolidated Health Plans at (413) 773-4540, toll-free at (800) 633-7867, or www.chpstudent.com for assistance.

NURSE HOTLINE FOR STUDENTS

For quick, sound medical advice from specially trained Nurses
24 hours a day, 365 days per year
Call toll free at 800-557-0309

EMERGENCY MEDICAL AND TRAVEL ASSISTANCE

Consolidated Health Plans provides access to a comprehensive program that will arrange emergency medical and travel assistance services, repatriation services and other travel assistance services when you are traveling. For general inquiries regarding the travel access assistance services coverage, please call Consolidated Health Plans at 1-800-633-7867. **If you are traveling and need assistance in North America, call the Assistance Center toll-free at: 877.305.1966 *or* if you are in a foreign country, call collect at: 715.295.9311**. When you call, please provide your name, school name, the group number shown on your ID card, and a description of your situation. If the condition is an emergency, you should go immediately to the nearest physician or hospital without delay and then contact the 24-hour Assistance Center.