SALVE REGINA UNIVERSITY STUDENT ACCIDENT AND SICKNESS INSURANCE PLAN

Underwritten by Companion Life Insurance Company, Columbia, SC

as Policy Form: BSHP-POL-RI et al

Policy Number: 2014I5A06 - Group Number: S201897

2014-2015 SUMMARY OF BENEFITS CHART

This is a schedule of benefits available through the Salve Regina University 2014-2015 Student Accident and Sickness Insurance Plan. This summary should be used in conjunction with the full plan description, including plan provisions, limitations and exclusions. You can obtain a copy of the full plan certificate at the School's Health Center, by calling University Health Plans at (800) 437-6448 or at www.universityhealthplans.com.

STUDENT PLAN COSTS *(Rates include an administrative fee retained by the servicing agent).*		
Annual (8/15/14-8/15/15)	**Fall** (8/15/14-1/15/15)	**Spring** (1/15/15-8/15/15)
$1,855	**$943**	**$1,041**

Policy Year Maximum Benefit	**Unlimited**
Out-of-Pocket Maximum (includes Coinsurance and Copayments; does not include non-covered medical expenses or elective treatment)	$6,350 per Individual
BASIC ACCIDENT AND SICKNESS MEDICAL EXPENSE BENEFITS[1]	
If as the result of any covered condition, an Insured Person incurs medical expenses, We will pay 100% of the Usual and Customary Expense incurred, as allocated below, up to a maximum of $5,000 after a $100 policy year deductible applicable to inpatient benefits only. The following benefits are subject to the imposition of Policy limits and exclusions. All coverage is based on Usual and Customary Expenses unless otherwise specified.	
Inpatient Hospitalization Benefits, after a $100 Policy Year Deductible	
Hospital Room and Board	U&C, up to the semi-private rate or ICU rate
Hospital Miscellaneous Expense, covered medical expenses include, but are not limited to, anesthesia, operating room, laboratory tests, x-rays, oxygen tent, drugs, medicines, dressings, and other medically necessary non-room and board expenses.	U&C
In Hospital Doctor's Visits Expense	U&C
Registered Nurse Service	U&C
Physical Rehabilitation	U&C
Preadmission Testing	U&C
Skilled Nursing Facility to a maximum of 120 days per Policy Year.	U&C
Surgical Benefits (Inpatient and Outpatient)	
Surgical Expense, covered medical expenses for charges for surgical services performed by a licensed Physician.	U&C
Anesthetist Expense, covered medical expenses for charges of an anesthetist during a surgical procedure.	U&C
Assistant Surgeon Expense, covered medical expenses for charges of an assistant surgeon during a surgical procedure.	U&C
Outpatient Expense, covered medical expenses include treatment at, but are not limited to, physician's office, hospital outpatient department, ambulatory surgery center, emergency room, urgent care center, clinical lab, radiological facility, or other similar facility licensed by the state. Outpatient expense will include coverage for one annual physical (with no co-pay). This benefit will include visits for Primary Care, Specialists, Chiropractic Care and other Licensed Practitioners. This benefit will also include one routine Adult Eye exam per Policy Year. Outpatient benefits in the Newport area are only payable with prior approval from the University Health Services. If the on-campus University Health Service is closed or not accessible due to a Medical Emergency, students should go to the Newport Hospital	Students should receive services at the University Health Services first. U&C, when services are rendered at Newport Hospital (80% of U&C for services provided other than Newport Hospital). Subject to the following co-pays: $20 co-pay per visit, if treated in a Physician's office $20 co-pay per visit, for all outpatient Newport Hospital visits* $100 co-pay per visit, if treated at a non-Newport Hospital Emergency Room or for a Non-Newport Hospital Outpatient Department visit or Urgent Care Center ***NOTE: The Newport Hospital co-payment will be waived in the following situations:** **1)** The Newport Hospital Emergency Room co-payment will be waived in the case of a medical emergency requiring Emergency Medical Care. **2)** The Newport Hospital outpatient co-payment will be waived for diagnostic work ordered by University Health Services.
Preventive Care, Screening, and Immunizations, expenses incurred for preventive care services provided by a Doctor, including STD testing. No co-pay, coinsurance or deductible will apply.	U&C
Ambulance Expense	U&C
Outpatient Rehabilitation and Habilitation Services, including outpatient physical therapy, occupational therapy, speech therapy, and cardiac rehabilitation,	U&C
Consultant Expense	U&C
Durable Medical Equipment, including braces and Appliances	U&C
Hospice	U&C
Home Health Care up to a maximum benefit of 40 visits per Policy Year.	U&C

Additional Benefits	
Prescription Drug Expense. Prescriptions must be filled at an Express Scripts Participating Pharmacy. Go to www.express-scripts.com to locate a participating pharmacy.	$10 co-pay for generic drug/$20 co-pay for brand name drug (Co-pays do not apply to generic contraceptives).
Sickness Dental Expense	100% of U&C, up to $125 maximum per tooth
Accidental Dental Expense	100% of U&C, up to a $250 maximum per Injury
Medical Evacuation	100%, up to $50,000 maximum per Policy Year
Repatriation	100%, up to $50,000 maximum per Policy Year
SUPPLEMENTAL ACCIDENT AND SICKNESS MEDICAL EXPENSE BENEFITS[1]	
If an Insured Person satisfies the Basic Accident and Sickness Benefits of $5,000, We will pay for 80% of the Usual and Customary Expense incurred in excess of $5,000., Hospital Room and Board Expenses are limited to the Usual and Customary Expense of a semi-private room rate. Benefits under the Supplemental Accident and Sickness Medical Expense Benefits will be payable for Usual and Customary Expenses incurred for any covered condition.	

Refer to Plan detail for additional benefits, state mandated benefits, limitations, exclusions, and definitions. The complete Plan certificate is available at the School's Health Center, by calling University Health Plans at (800) 437-6448 or at www.universityhealthplans.com.

Note: Intercollegiate Sports Expense will be covered under a separate policy up to $1,500 maximum per Injury.

State Mandated Benefits State mandated benefits will be subject to all deductible, co-payment, co-insurance, limitations, or any other provision of the Policy. If any Preventive Services Benefit is subject to the mandated benefits required by state law, they will be administered under the federal or state guideline, whichever is more favorable to the student.

State Mandated Benefits include: Pediatric Preventive Care; Infertility Expense; Mastectomy Surgery and Rehabilitation Benefit; Mastectomy Hospital Stay Benefit; Diabetes Treatment Expense Benefit; New Cancer Therapies Expense; Mammography Expense; Cytological Screening Expense; Prostate and Colorectal Cancer Screening Expense; Leukocyte Testing Expense; Postpartum Hospital Stay Expense; Early Intervention Services for Dependent Children; Hearing Aids; Lyme Disease Treatment; Off-Label Drug Treatments; Tobacco Cessation Treatment; Scalp Hair Prosthesis; Coverage for Orthotic and Prosthetic Services; Non-prescription Enteral Nutrition Products Expense; Ambulance Service Expense; Pediatric Vision Care Benefit; Pediatric Preventive Dental Care Benefit; Mental Illness and Substance Abuse Expense Benefit.

COORDINATION OF BENEFITS PROVISION

All benefits above $225 per Accident provided under this Plan will be coordinated with any other valid and collectible insurance that is in force to an Insured Person and are subject to the conditions and limitations of this Plan. Sickness Expense Benefits are paid on a primary basis.

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EXCLUSIONS & LIMITATIONS

Any Exclusion in conflict with the Patient Protection and Affordable Care Act or Mandated Benefits will be revised to comply and provide coverage as specifically stated in the Policy. Any Exclusion in direct conflict will be deleted in its entirety. The Plan does not provide coverage for loss caused by or resulting from:

1. Charges that are not Medically Necessary or in excess of the Usual and Customary charge.
2. Expenses in connection with services and prescriptions for eye examinations, eye refractions, eye glasses or contact lenses, or the fitting of eyeglasses or contact lenses, radial keratotomy or laser surgery for vision correction or the treatment of visual defects or problems, except as specifically provided for in the Policy.
3. Skeletal irregularities of one or both jaws including Temporomandibular Joint Dysfunction (TMJ); orthognathia and mandibular retrognathia; nasal or sinus surgery;
4. Expenses in connection with cosmetic treatment or cosmetic surgery, except as a result of: a) a covered Injury that occurred while the Covered Person was insured; b) a covered child's congenital defect or anomaly; or c) as specifically provided for in the Policy.
5. Injuries arising out of playing or participating in an intercollegiate sport, contest or competition, traveling to or from such sport contest or competition as a participant; or participation in any practice or conditioning program for such sport, contest, or competition(intercollegiate sports will be covered under a separate Policy up to $1,500).
6. War, or any act of war, whether declared or undeclared; service in the Armed Forces of any country.
7. Loss which occurs during or as a result of committing or attempting to commit an assault, felony, or participation in a riot or insurrection, engaging in an illegal occupation.
8. Expenses incurred for Injury or Sickness for which benefits are paid or payable under any Worker's Compensation or Occupational Disease Law or Act, or similar legislation.
9. Treatment, services, supplies in a Veteran's Administration or Hospital owned or operated by a national government or its agencies unless there is a legal obligation for the Covered Person to pay for the treatment.
10. Expenses incurred for dental care or treatment of the teeth, gums or structures directly supporting the teeth, including surgical extractions of teeth. This exclusion does not apply to the repair of Injuries to sound natural teeth caused by a covered Injury, and specifically provided in the hospitalization and Anesthesia for Dental Procedures expense benefit or pediatric dental care, except as specifically provided by the Policy.
11. Elective Surgery or Elective Treatment (including termination of pregnancy) as defined by the Policy.
12. Immunizations, except as specifically provided in the Policy; preventive medicines or vaccines, except when required for treatment of a covered Injury or as specifically provided in the Policy.
13. Routine physical examination and routine testing; preventive testing or treatment; screening exams or testing in the absence of any Injury or Sickness, except as specifically provided by the Policy.
14. Foot care including: flat foot conditions, supportive devices for the foot, subluxations, care of corns, bunions (except capsular or bone surgery), calluses, toenails, fallen arches, week feet, foot strain, and symptomatic complaints of the feet, except those related to diabetic care
15. Expenses incurred for Acupuncture.

WHERE TO FIND HELP

For questions about:	Please contact:
Enrollment Waiver of mandatory insurance charge Insurance Benefits	**University Health Plans** One Batterymarch Park, Quincy, MA 02169-7454 Local: (617) 472-5324 - Out of area: (800) 437-6448 - www.universityhealthplans.com
Insurance Benefits Claims Processing ID Cards	**Consolidated Health Plans** 2077 Roosevelt Avenue, Springfield, MA 01104 Local: (413) 733-4540 - Out of area: (800) 633-7867 - www.chpstudent.com