PART V
SCHEDULE OF BENEFITS
MEDICAL EXPENSE BENEFITS
DAVIDSON COLLEGE - STUDENT PLAN
2014-927-1

INJURY AND SICKNESS BENEFITS
METALLIC LEVEL:

<table>
<thead>
<tr>
<th>Maximum Benefit</th>
<th>No Overall Maximum Dollar Limit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductible</td>
<td>$50 (Per Insured Person, Per Policy Year)</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>80% except as noted below</td>
</tr>
<tr>
<td>Out-of-Pocket Maximum</td>
<td>$3,000 (Per Insured Person, Per Policy Year)</td>
</tr>
<tr>
<td>Out-of-Pocket Maximum</td>
<td>$6,000 (For all Insureds in a Family, Per Policy Year)</td>
</tr>
</tbody>
</table>

**Out-of-Pocket Maximum:** After the Out-of-Pocket Maximum has been satisfied, Covered Medical Expenses will be paid at 100% for the remainder of the Policy Year subject to any benefit maximums or limits that may apply. Any applicable Copays or Deductibles will be applied to the Out-of-Pocket Maximum. Services that are not Covered Medical Expenses and the amount benefits are reduced for failing to comply with policy provisions or requirements do not count toward meeting the Out-of-Pocket Maximum.

The benefits payable are as defined in and subject to all provisions of this policy and any endorsements thereto. Benefits are calculated on a Policy Year basis unless otherwise specifically stated. When benefit limits apply, benefits will be paid up to the maximum benefit for each service as scheduled below.

### Inpatient

- **Room & Board Expense:** Usual and Customary Charges
- **Intensive Care:** Usual and Customary Charges
- **Hospital Miscellaneous Expenses:** Usual and Customary Charges
- **Routine Newborn Care:** Usual and Customary Charges
- **Surgery:** Usual and Customary Charges
  
  *(If two or more procedures are performed through the same incision or in immediate succession at the same operative session, the maximum amount paid will not exceed 50% of the second procedure and 50% of all subsequent procedures.)*

- **Assistant Surgeon Fees:** Usual and Customary Charges
- **Anesthetist Services:** Usual and Customary Charges
- **Registered Nurse’s Services:** Usual and Customary Charges
- **Physician's Visits:** Usual and Customary Charges
  
  *$10 Deductible per visit*

- **Pre-admission Testing:** Usual and Customary Charges
  
  *(Pre-admission testing must occur within 7 days prior to admission.)*
Outpatient Surgery: Usual and Customary Charges
(If two or more procedures are performed through the same incision or in immediate succession at the same operative session, the maximum amount paid will not exceed 50% of the second procedure and 50% of all subsequent procedures.)

Day Surgery Miscellaneous: Usual and Customary Charges
(Usual and Customary Charges for Day Surgery Miscellaneous are based on the Outpatient Surgical Facility Charge Index.)

Assistant Surgeon Fees: Usual and Customary Charges
Anesthetist Services: Usual and Customary Charges
Physician's Visits: Usual and Customary Charges
($10 per visit Deductible applies to Sickness only and will be waived if referred by the Student Health Center.)

Physiotherapy: Usual and Customary Charges
(Review of Medical Necessity will be performed after 12 visits per Injury or Sickness.)

Medical Emergency Expenses: Usual and Customary Charges
(Treatment must be rendered within 72 hours from the time of Injury or first onset of Sickness.)

Diagnostic X-ray Services: Usual and Customary Charges
Radiation Therapy: Usual and Customary Charges
Laboratory Procedures: Usual and Customary Charges
Tests & Procedures: Usual and Customary Charges
Injections: Usual and Customary Charges
Chemotherapy: Usual and Customary Charges

Prescription Drugs: HealthSmartRx
$10 Copay per prescription for generic drugs
$20 Copay per prescription for brand name drugs
$40 Copay per prescription for specialty drugs
up to a 31 day supply per prescription
<table>
<thead>
<tr>
<th>Service</th>
<th>Payment Method</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ambulance Services:</td>
<td>Usual and Customary Charges</td>
</tr>
<tr>
<td>Durable Medical Equipment:</td>
<td>Usual and Customary Charges</td>
</tr>
<tr>
<td>Consultant Physician Fees:</td>
<td>Usual and Customary Charges</td>
</tr>
<tr>
<td>Dental Treatment:</td>
<td>Usual and Customary Charges</td>
</tr>
<tr>
<td>(Benefits paid on Injury to Sound, Natural Teeth only.)</td>
<td>Paid as any other Sickness</td>
</tr>
<tr>
<td>Mental Illness Treatment:</td>
<td>Paid as any other Sickness</td>
</tr>
<tr>
<td>(Institutions specializing in or primarily treating Mental Illness are not covered.)</td>
<td></td>
</tr>
<tr>
<td>Substance Use Disorder Treatment:</td>
<td>Paid as any other Sickness</td>
</tr>
<tr>
<td>Maternity:</td>
<td>Paid as any other Sickness</td>
</tr>
<tr>
<td>Elective Abortion:</td>
<td>No Benefits</td>
</tr>
<tr>
<td>Complications of Pregnancy:</td>
<td>Paid as any other Sickness</td>
</tr>
<tr>
<td>Preventive Care Services:</td>
<td>100% of Usual and Customary Charges</td>
</tr>
<tr>
<td>(No Deductible or Coinsurance will be applied to Preventive Care Services.)</td>
<td>Paid as any other Sickness</td>
</tr>
<tr>
<td>Reconstructive Breast Surgery Following</td>
<td>Paid as any other Sickness</td>
</tr>
<tr>
<td>Mastectomy:</td>
<td>See Benefits for Reconstructive Breast Surgery Following Mastectomy</td>
</tr>
<tr>
<td>Diabetes Services:</td>
<td>Paid as any other Sickness</td>
</tr>
<tr>
<td>Home Health Care:</td>
<td>See Benefits for Diabetes</td>
</tr>
<tr>
<td>Hospice Care:</td>
<td>Usual and Customary Charges</td>
</tr>
<tr>
<td>Skilled Nursing Facility:</td>
<td>Usual and Customary Charges</td>
</tr>
<tr>
<td>Urgent Care Center:</td>
<td>Usual and Customary Charges</td>
</tr>
<tr>
<td>Hospital Outpatient Facility or Clinic:</td>
<td>Usual and Customary Charges</td>
</tr>
<tr>
<td>Approved Clinical Trials:</td>
<td>Paid as any other Sickness</td>
</tr>
<tr>
<td>Transplantation Services:</td>
<td>See Benefits for Covered Clinical Trials</td>
</tr>
<tr>
<td>*Pediatric Dental and Vision Services:</td>
<td>Paid as any other Sickness</td>
</tr>
<tr>
<td>Medical Supplies:</td>
<td>See endorsements attached for Pediatric Dental and Vision Services benefits</td>
</tr>
<tr>
<td>(Benefits are limited to a 31-day supply per purchase.)</td>
<td>Paid as any other Sickness</td>
</tr>
<tr>
<td>Ostomy Supplies:</td>
<td>Usual and Customary Charges</td>
</tr>
<tr>
<td>Club Sports:</td>
<td>Usual and Customary Charges</td>
</tr>
</tbody>
</table>

Continuation Permitted: Yes ( ) No (X)

(X) Extension of Benefits

Other Insurance: ( ) Excess Insurance (X) Primary Insurance

*If benefit is designated, see endorsement attached.
PART VIII
EXCLUSIONS AND LIMITATIONS

No benefits will be paid for: a) loss or expense caused by, contributed to, or resulting from; or b) treatment, services or supplies for, at, or related to any of the following:

1. Acne.
2. Acupuncture.
3. Addiction, such as:
   - Caffeine addiction.
   - Non-chemical addiction, such as: gambling, sexual, spending, shopping, working and religious.
   - Codependency.
   This exclusion does not apply to benefits specifically provided in the policy or to any screening or assessment specifically provided under the Preventive Care Services benefit.
6. Circumcision, except as specifically provided for a Newborn Infant during an Inpatient maternity Hospital stay provided under the Benefits for Maternity Expenses.
7. Congenital Conditions, except as specifically provided for:
   - Habilitative Services.
   - Newborn Infants and Adopted or Foster Children.
8. Cosmetic procedures, except reconstructive procedures to:
   - Correct an Injury or treat a Sickness for which benefits are otherwise payable under this policy. The primary result of the procedure is not a changed or improved physical appearance.
   - Treat or correct Congenital Conditions of a Newborn Infant and Adopted or Foster Child.
9. Custodial Care.
   - Care provided in: rest homes, health resorts, homes for the aged, halfway houses, college infirmaries or places mainly for domiciliary or Custodial Care.
   - Extended care in treatment or substance abuse facilities for domiciliary or Custodial Care.
10. Dental treatment, except:
    - For accidental Injury to Sound, Natural Teeth.
    This exclusion does not apply to any screening or assessment specifically provided under the Preventive Care Services benefit or benefits specifically provided in Pediatric Dental Services.
11. Elective Surgery or Elective Treatment.
12. Elective abortion.
13. Flight in any kind of aircraft, except while riding as a passenger on a regularly scheduled flight of a commercial airline.
14. Foot care for the following, except as specifically provided in the policy:
    - Flat foot conditions.
    - Supportive devices for the foot, except for foot orthotics custom molded to the Insured.
    - Subluxations of the foot.
    - Fallen arches.
    - Weak feet.
    - Chronic foot strain.
    - Routine foot care including the care, cutting and removal of corns, calluses, toenails, and bunions (except capsular or bone surgery).
    This exclusion does not apply to preventive foot care for Insured Persons with diabetes.
15. Health spa or similar facilities. Strengthening programs.

16. Hearing examinations, except as specifically provided in the Benefits for Newborn Hearing Screening. Hearing aids, except as specifically provided in the Benefits for Hearing Aids. Other treatment for hearing defects and hearing loss. "Hearing defects" means any physical defect of the ear which does or can impair normal hearing, apart from the disease process.

This exclusion does not apply to:
• Hearing defects or hearing loss as a result of an infection or injury.
• Any screening or assessment specifically provided under the Preventive Care Services benefit.

17. Hypnosis.

18. Immunizations, except as specifically provided in the policy. Preventive medicines or vaccines, except where required for treatment of a covered injury or as specifically provided in the policy.

This exclusion does not apply to any screening or assessment specifically provided under the Preventive Care Services benefit.

19. Services or supplies for the treatment of an occupational injury or sickness which are paid under the North Carolina Worker’s Compensation Act only to the extent such services or supplies are the liability of the employee, employer or workers compensation insurance carrier according to a final adjudication under the North Carolina Workers’ Compensation Act or an order of the North Carolina Industrial Commission approving a settlement agreement under the North Carolina Workers’ Compensation Act.

20. Injury sustained while:
• Participating in any intercollegiate, or professional sport, contest or competition.
• Traveling to or from such sport, contest or competition as a participant.
• Participating in any practice or conditioning program for such sport, contest or competition.

21. Investigational services, except as specifically provided in the Benefits for Covered Clinical Trials.

22. Lipectomy.

23. Voluntary participation in a riot or civil disorder. Commission of or attempt to commit a felony. Fighting, except when as a direct result of domestic abuse.

24. Prescription Drugs, services or supplies as follows, except as specifically provided in the policy:
• Therapeutic devices or appliances, including: hypodermic needles, syringes, support garments and other non-medical substances, regardless of intended use, except as specifically provided in the policy or specifically provided in Benefits for Diabetes.
• Immunization agents, except as specifically provided in the policy. Biological sera.
• Drugs labeled, “Caution - limited by federal law to investigational use” or experimental drugs except for drugs for the treatment of cancer that have not been approved by the Federal Food and Drug Administration, provided the drug is recognized for treatment of the specific type of cancer for which the drug has been prescribed in one of the following established reference compendia: (1) The National Comprehensive Cancer Network Drugs and Biologies Compendium; (2) The Thomson Micromedex DrugDex; (3) The Elsevier Gold Standard’s Clinical Pharmacology; or (4) Any other authoritative compendia as recognized periodically by the United States Secretary of Health and Human Services.
• Products used for cosmetic purposes.
• Drugs used to treat or cure baldness. Anabolic steroids used for body building.
• Anorectics - drugs used for the purpose of weight control.
• Growth hormones, except for a Newborn Infant, Adopted or Foster Child who requires growth hormones for the treatment of a Congenital Condition.
• Refills in excess of the number specified or dispensed after one (1) year of date of the prescription.
25. Reproductive/Infertility services including but not limited to the following, except as specifically provided in the policy:
   • Procreative counseling.
   • Genetic counseling and genetic testing.
   • Cryopreservation of reproductive materials. Storage of reproductive materials.
   • Fertility tests.
   • Infertility treatment (male or female), including any services or supplies rendered for the purpose or with the intent of
     inducing conception, except to diagnose or treat the underlying cause of the infertility.
   • Premarital examinations.
   • Reversal of sterilization procedures.
   • Sexual reassignment surgery.

26. Research or examinations relating to research studies, or any treatment for which the patient or the patient’s representative
    must sign an informed consent document identifying the treatment in which the patient is to participate as a research study
    or clinical research study, except as specifically provided in the Benefits for Covered Clinical Trials.

27. Routine eye examinations. Eye refractions. Eyeglasses. Contact lenses. Prescriptions or fitting of eyeglasses or contact

    This exclusion does not apply as follows:
    • When due to a covered Injury or disease process.
    • To benefits specifically provided in Pediatric Vision Services.
    • To therapeutic contact lenses when used as a corneal bandage.
    • To one pair of eyeglasses or contact lenses due to a prescription change following cataract surgery.
    • To any screening or assessment specifically provided under the Preventive Care Services benefit.

28. Routine Newborn Infant Care and well-baby nursery and related Physician charge, except as specifically provided in the
    policy.

29. Preventive care services, except as specifically provided in the policy, including:
    • Routine physical examinations and routine testing.
    • Preventive testing or treatment.
    • Screening exams or testing in the absence of Injury or Sickness.

    This exclusion does not apply to any screening or assessment specifically provided under the Preventive Care Services
    benefit or any North Carolina mandated benefit included under the policy.

30. Services provided normally without charge by the Health Service of the Policyholder. Services covered or provided by the
    student health fee.

31. Deviated nasal septum, including submucous resection and/or other surgical correction thereof. Nasal and sinus surgery,
    except for treatment of a covered Injury or treatment of chronic sinusitis.

32. Speech therapy, except as specifically provided in the policy. Naturopathic services.

33. Stand-alone multi-disciplinary smoking cessation programs. These are programs that usually include health care providers
    specializing in smoking cessation and may include a psychologist, social worker or other licensed or certified professional.

34. Supplies, except as specifically provided in the policy.

35. Surgical breast reduction, breast augmentation, breast implants or breast prosthetic devices, or gynecomastia, except as
    specifically provided in the policy.

36. Treatment in a Government hospital, unless there is a legal obligation for the Insured Person to pay for such treatment.

37. War or any act of war, declared or undeclared; or while in the armed forces of any country (a pro-rata premium will be
    refunded upon request for such period not covered).

    Surgery for removal of excess skin or fat.