Schedule of Benefits

College of William & Mary
2020-1404-2
METALLIC LEVEL – GOLD WITH ACTUARIAL VALUE OF 83.890%
Injury and Sickness Benefits

No Overall Maximum Dollar Limit (Per Insured Person, Per Policy Year)

Deductible	$150 (Per Insured Person, Per Policy Year)
Coinsurance Preferred Provider	80% of Preferred Allowance except as noted below
Coinsurance Out-of-Network	50% of Usual and Customary Charges except as noted below
Out-of-Pocket Maximum Preferred Provider	$7,350 (Per Insured Person, Per Policy Year)
Out-of-Pocket Maximum Preferred Provider	$14,700 (For all Insureds in a Family, Per Policy Year)

The Policy provides benefits for the Covered Medical Expenses incurred by an Insured Person for loss due to a covered Injury or Sickness.

The Preferred Provider for this plan UnitedHealthcare Options PPO.

If care is received from a Preferred Provider any Covered Medical Expenses will be paid at the Preferred Provider level of benefits. If a Preferred Provider is not available in the Network Area, benefits will be paid at the level of benefits shown as Preferred Provider benefits. If the Covered Medical Expense is incurred for Emergency Services when due to a Medical Emergency, benefits will be paid at the Preferred Provider level of benefits. In all other situations, reduced or lower benefits will be provided when an Out-of-Network provider is used.

Deductible: The Per Insured Person Deductible applies to each person covered under the Policy each Policy Year.

Out-of-Pocket Maximum: The Per Insured Person Out-of-Pocket Maximum applies to each person covered under the Policy each Policy Year. After the Out-of-Pocket Maximum has been satisfied, Covered Medical Expenses will be paid at 100% for the remainder of the Policy Year for that person. However, after the Out-of-Pocket Maximum for Insured Persons in a family collectively totals the For all Insureds in a Family Out-of-Pocket Maximum in a Policy Year, Covered Medical Expenses will be paid at 100% for any insured family member for the remainder of the Policy Year. Any applicable Coinsurance, 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.

Student Health Center Benefits:
1) The Deductible and Copays will be waived and benefits will be paid at 100% for Covered Medical Expenses incurred when treatment is rendered at the Student Health Center for the following services: Outpatient Physician's Visits.
2) The Deductible will be waived and benefits will be paid at 100% for Covered Medical Expenses incurred when treatment is rendered at the Student Health Center for the following services:

a) Prescription Drugs after a $5 Copay per prescription for generic and $15 Copay per prescription for brand-name drugs, up to a 31-day supply per prescription;
b) Laboratory Procedures after a $10 Copay; and
c) All other services listed in the Schedule of Benefits.

Copays: The following Copays specified in the Schedule of Benefits are in addition to the Policy Deductible: Room and Board Expense.

Out-of-Country Claims: Benefits will be paid at 80% of Usual and Customary Charges for Covered Medical Expenses incurred when treatment is received outside the United States.

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. All benefit maximums are combined Preferred Provider and Out-of-Network unless otherwise specifically stated. Please refer to the Medical Expense Benefits – Injury and Sickness section of the Certificate of Coverage for a description of the Covered Medical Expenses for which benefits are available. Covered Medical Expenses include:

Inpatient	Preferred Provider	Out-of-Network Provider
Room and Board Expense	$250 Copay per Hospital Confinement Preferred Allowance after Deductible	$250 Copay per Hospital Confinement Usual and Customary Charges after Deductible
Intensive Care	Preferred Allowance after Deductible	Usual and Customary Charges after Deductible
Hospital Miscellaneous Expenses	Preferred Allowance after Deductible	Usual and Customary Charges after Deductible
Routine Newborn Care	Paid as any other Sickness	Paid as any other Sickness
Surgery 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.	Preferred Allowance after Deductible	Usual and Customary Charges after Deductible
Assistant Surgeon Fees	Preferred Allowance after Deductible	Usual and Customary Charges after Deductible
Anesthetist Services	Preferred Allowance after Deductible	80% of Usual and Customary Charges after Deductible
Registered Nurse's Services	Preferred Allowance after Deductible	Usual and Customary Charges after Deductible
Physician's Visits	Preferred Allowance after Deductible	Usual and Customary Charges after Deductible
Pre-admission Testing Payable within 7 working days prior to admission.	Preferred Allowance after Deductible	Usual and Customary Charges after Deductible

Outpatient	Preferred Provider	Out-of-Network Provider
Surgery 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.	Preferred Allowance after Deductible	Usual and Customary Charges after Deductible
Day Surgery Miscellaneous	Preferred Allowance after Deductible	Usual and Customary Charges after Deductible
Assistant Surgeon Fees	Preferred Allowance after Deductible	Usual and Customary Charges after Deductible
Anesthetist Services	Preferred Allowance after Deductible	80% of Usual and Customary Charges after Deductible
Physician's Visits	$25 Copay per visit 100% of Preferred Allowance not subject to Deductible	$25 Copay per visit 70% of Usual and Customary Charges not subject to Deductible
Physiotherapy Review of Medical Necessity will be performed after 12 visits per Injury or Sickness.	$20 Copay per visit Preferred Allowance not subject to Deductible	$20 Copay per visit 80% of Usual and Customary Charges not subject to Deductible
Medical Emergency Expenses	$100 Copay per visit	$100 Copay per visit

Outpatient	Preferred Provider	Out-of-Network Provider
The Copay will be waived if admitted to the Hospital.	100% of Preferred Allowance not subject to Deductible	100% of Preferred Allowance not subject to Deductible
Diagnostic X-ray Services	Preferred Allowance after Deductible	Usual and Customary Charges after Deductible
Radiation Therapy	Preferred Allowance after Deductible	Usual and Customary Charges after Deductible
Laboratory Procedures	Preferred Allowance after Deductible	Usual and Customary Charges after Deductible
Tests & Procedures	Preferred Allowance after Deductible	Usual and Customary Charges after Deductible
Injections	Preferred Allowance after Deductible	Usual and Customary Charges after Deductible
Chemotherapy	Preferred Allowance after Deductible	Usual and Customary Charges after Deductible
Prescription Drugs *See UHCP Prescription Drug Benefit Endorsement for additional information.	*UnitedHealthcare Pharmacy (UHCP), $30 Copay per prescription Tier 1 $60 Copay per prescription Tier 2 25% Coinsurance per prescription Tier 3 up to a 31-day supply per prescription not subject to Deductible When Specialty Prescription Drugs are dispensed at a Non-Preferred Specialty Network Pharmacy, the Insured is required to pay 2 times the retail Copay and/or Coinsurance (up to 50% of the Prescription Drug Charge). Mail order Prescription Drugs through UHCP at 2.5 times the retail Copay up to a 90-day supply	No Benefits

Other	Preferred Provider	Out-of-Network Provider
Ambulance Services	Preferred Allowance after Deductible	80% of Usual and Customary Charges after Deductible
Durable Medical Equipment When services for Prosthetic Devices are provided by a Preferred Provider, the Insured's portion of the Coinsurance shall not exceed 30% for such Prosthetic Device.	Preferred Allowance after Deductible	80% of Usual and Customary Charges after Deductible
Consultant Physician Fees	Paid under Physician's Visits	Paid under Physician's Visits
Dental Treatment	Paid as any other Injury or Sickness	Paid as any other Injury or Sickness

Other	Preferred Provider	Out-of-Network Provider
Mental Illness Treatment See also Benefits for Mental Illness and Substance Use Disorder	**Inpatient:** $250 Copay per Hospital Confinement Preferred Allowance after Deductible **Outpatient office visits:** $20 Copay per visit 100% of Preferred Allowance not subject to Deductible **All other outpatient services, except Medical Emergency Expenses and Prescription Drugs:** Preferred Allowance after Deductible	**Inpatient:** $250 Copay per Hospital Confinement Usual and Customary Charges after Deductible **Outpatient office visits:** $20 Copay per visit 70% of Usual and Customary Charges not subject to Deductible **All other outpatient services, except Medical Emergency Expenses and Prescription Drugs:** Usual and Customary Charges after Deductible
Substance Use Disorder Treatment See also Benefits for Mental Illness and Substance Use Disorder	**Inpatient:** $250 Copay per Hospital Confinement Preferred Allowance after Deductible **Outpatient office visits:** $20 Copay per visit 100% of Preferred Allowance not subject to Deductible **All other outpatient services, except Medical Emergency Expenses and Prescription Drugs:** Preferred Allowance after Deductible	**Inpatient:** $250 Copay per Hospital Confinement Usual and Customary Charges after Deductible **Outpatient office visits:** $20 Copay per visit 70% of Usual and Customary Charges not subject to Deductible **All other outpatient services, except Medical Emergency Expenses and Prescription Drugs:** Usual and Customary Charges after Deductible
Maternity	Paid as any other Sickness	Paid as any other Sickness
Complications of Pregnancy	Paid as any other Sickness	Paid as any other Sickness
Elective Abortion	No Benefits	No Benefits
Preventive Care Services No Deductible, Copays, or Coinsurance will be applied when the services are received from a Preferred Provider. Please visit https://www.healthcare.gov/preventive-care-benefits/ for a complete list of services provided for specific age and risk groups.	100% of Preferred Allowance	No Benefits
Reconstructive Breast Surgery Following Mastectomy See Benefits for Reconstructive Breast Surgery Following Mastectomy	Paid as any other Sickness	Paid as any other Sickness
Diabetes Services See also Benefits for Diabetes	Paid as any other Sickness	Paid as any other Sickness
Home Health Care 100 visits maximum per Policy Year	Preferred Allowance after Deductible	Usual and Customary Charges after Deductible
Hospice Care See Benefits for Hospice Care	Paid as any other Sickness	Paid as any other Sickness

Other	Preferred Provider	Out-of-Network Provider
Inpatient Rehabilitation Facility	Preferred Allowance after Deductible	Usual and Customary Charges after Deductible
Skilled Nursing Facility	Preferred Allowance after Deductible	Usual and Customary Charges after Deductible
Urgent Care Center	$20 Copay per visit 100% of Preferred Allowance not subject to Deductible	$20 Copay per visit 70% of Usual and Customary Charges not subject to Deductible
Hospital Outpatient Facility or Clinic	Preferred Allowance after Deductible	Usual and Customary Charges after Deductible
Approved Clinical Trials See also Benefits for Clinical Trials for Treatment Studies on Cancer	Paid as any other Sickness	Paid as any other Sickness
Transplantation Services	Paid as any other Sickness	Paid as any other Sickness
Pediatric Dental and Vision Services	See endorsements attached for Pediatric Dental and Vision Services benefits	See endorsements attached for Pediatric Dental and Vision Services benefits
Allergy Testing/Treatment	Paid as any other Sickness	Paid as any other Sickness
Dialysis	Paid as any other Sickness	Paid as any other Sickness
Genetic Testing	Paid as any other Sickness	Paid as any other Sickness
Infertility	Paid as any other Sickness	Paid as any other Sickness
Infusion Therapy	Paid as any other Sickness	Paid as any other Sickness
Lymphedema	Paid as any other Sickness	Paid as any other Sickness
Medical Foods	Preferred Allowance after Deductible	Usual and Customary Charges after Deductible
Medical Supplies Benefits are limited to a 31-day supply per purchase.	Preferred Allowance after Deductible	Usual and Customary Charges after Deductible
Oral and Maxillofacial Surgery	Paid as any other Sickness	Paid as any other Sickness
Ostomy Supplies	Preferred Allowance after Deductible	Usual and Customary Charges after Deductible
Sleep Disorders	Paid as any other Sickness	Paid as any other Sickness
TMJ Disorders	Paid as any other Sickness	Paid as any other Sickness
Vision Correction	Preferred Allowance after Deductible	Usual and Customary Charges after Deductible
Wigs	Preferred Allowance after Deductible	Usual and Customary Charges after Deductible
Routine Adult Vision Benefits are limited to one routine eye examination and one pair of eyeglasses per Policy Year. This benefit is separate from and does not apply to Pediatric Vision Services.	Preferred Allowance after Deductible	Usual and Customary Charges after Deductible
Adult Dental Examination Benefits are limited to one dental examination per Policy Year. This benefit is separate from and does not apply to Pediatric Dental Services.	80% of Usual and Customary Charges after Deductible	80% of Usual and Customary Charges after Deductible