UNITEDHEALTHCARE INSURANCE COMPANY

Schedule of Benefits

William & Mary
2024-1404-2
METALLIC LEVEL – GOLD WITH ACTUARIAL VALUE OF 87.220%
Injury and Sickness Benefits

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

Deductible Preferred Provider	$150 (Per Insured Person, Per Policy Year)
Deductible Out-of-Network Provider	$300 (Per Insured Person, Per Policy Year)
Coinsurance Preferred Provider	80% of Allowed Amount, except as noted below
Coinsurance Out-of-Network Provider	50% of Allowed Amount, 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 Choice Plus.

Preferred Provider Benefits apply to Covered Medical Expenses that are provided by a Preferred Provider. If a Preferred Provider is not available in the Network Area, benefits will be paid for Covered Medical Expenses provided by an Out-of-Network Provider at the Preferred Provider Benefit level. “Network area” means the 10 mile radius around the local school campus the Named Insured is attending.

Out-of-Network Provider Benefits apply to Covered Medical Expenses that are provided by an Out-of-Network Provider. Refer to the *Preferred Provider and Out-of-Network Provider Information* section of the Certificate for information on reimbursement for Emergency Services provided by an Out-of-Network Provider, Covered Medical Expenses provided at certain Preferred Provider facilities by an Out-of-Network Physician, and Air Ambulance transport provided by an Out-of-Network Provider.

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 per visit; and
c) All other services listed in the Schedule of Benefits.

Out-of-Country Claims: Covered Medical Expenses incurred outside the United States will be paid at 80% of the Allowed Amount.

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 Provider unless otherwise specifically stated. Please refer to the Medical Expense Benefits 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 Benefits	Out-of-Network Provider Benefits
Room and Board Expense	$250 Copay per Hospital Confinement Allowed Amount after Deductible	$250 Copay per Hospital Confinement Allowed Amount after Deductible
Intensive Care	Allowed Amount after Deductible	Allowed Amount after Deductible
Hospital Miscellaneous Expenses	Allowed Amount after Deductible	Allowed Amount 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.	Allowed Amount after Deductible	Allowed Amount after Deductible
Assistant Surgeon Fees 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.	Allowed Amount after Deductible	Allowed Amount after Deductible
Anesthetist Services	Allowed Amount after Deductible	80% of Allowed Amount after Deductible
Registered Nurse's Services	Allowed Amount after Deductible	Allowed Amount after Deductible
Physician's Visits	Allowed Amount after Deductible	Allowed Amount after Deductible
Pre-admission Testing Payable within 7 working days prior to admission.	Allowed Amount after Deductible	Allowed Amount after Deductible

Outpatient	Preferred Provider Benefits	Out-of-Network Provider Benefits
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.	Allowed Amount after Deductible	Allowed Amount after Deductible
Day Surgery Miscellaneous	Allowed Amount after Deductible	Allowed Amount after Deductible
Assistant Surgeon Fees If two or more procedures are performed through the same incision	Allowed Amount after Deductible	Allowed Amount after Deductible

Outpatient	Preferred Provider Benefits	Out-of-Network Provider Benefits
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.		
Anesthetist Services	Allowed Amount not subject to Deductible	80% of Allowed Amount not subject to Deductible
Physician's Visits	$25 Copay per visit 100% of Allowed Amount not subject to Deductible	$25 Copay per visit 70% of Allowed Amount not subject to Deductible
Physiotherapy Review of Medical Necessity will be performed after 12 visits per Injury or Sickness.	$20 Copay per visit Allowed Amount not subject to Deductible	$20 Copay per visit 80% of Allowed Amount not subject to Deductible
Medical Emergency Expenses The Copay will be waived if admitted to the Hospital.	$100 Copay per visit 100% of Allowed Amount not subject to Deductible	$100 Copay per visit 100% of Allowed Amount not subject to Deductible
Diagnostic X-ray Services	Allowed Amount not subject to Deductible	Allowed Amount not subject to Deductible
Radiation Therapy	Allowed Amount after Deductible	Allowed Amount after Deductible
Laboratory Procedures	Allowed Amount not subject to Deductible	Allowed Amount not subject to Deductible
Tests & Procedures	Allowed Amount after Deductible	Allowed Amount after Deductible
Injections	Allowed Amount after Deductible	Allowed Amount after Deductible
Chemotherapy	Allowed Amount after Deductible	Allowed Amount after Deductible
Prescription Drugs *See UHCP Prescription Drug Benefit Endorsement for additional information. For insulin drugs the total amount of Deductible, Copayments or Coinsurance shall not exceed $50 for an individual prescription of up to a 30-day supply. Mail Order Network Pharmacy or Preferred 90 Day Retail Network Pharmacy for insulin drugs the total amount of Deductible, Copayments or Coinsurance shall not exceed $150 for an individual prescription of up to a 90-day supply.	*UnitedHealthcare Pharmacy (UHCP), Retail Network Pharmacy $15 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). UHCP Mail Order Network Pharmacy or Preferred 90 Day Retail Network Pharmacy at 2.5 times the retail Copay up to a 90-day supply	No Benefits

Other	Preferred Provider Benefits	Out-of-Network Provider Benefits
Ambulance Services	Allowed Amount after Deductible	80% of Allowed Amount after Deductible

Other	Preferred Provider Benefits	Out-of-Network Provider Benefits
Durable Medical Equipment See also Benefits for Prosthetic Devices.	80% of Allowed Amount after Deductible	80% of Allowed Amount after Deductible
Consultant Physician Fees	$25 Copay per visit 100% of Allowed Amount not subject to Deductible	$25 Copay per visit 70% of Allowed Amount not subject to Deductible
Dental Treatment	Paid as any other Injury or Sickness	Paid as any other Injury or Sickness
Mental Illness Treatment See also Benefits for Mental Illness and Substance Use Disorder	**Inpatient:** $250 Copay per Hospital Confinement Allowed Amount after Deductible **Outpatient office visits:** $20 Copay per visit 100% of Allowed Amount not subject to Deductible **All other outpatient services, except Medical Emergency Expenses and Prescription Drugs:** Allowed Amount after Deductible	**Inpatient:** $250 Copay per Hospital Confinement Allowed Amount after Deductible **Outpatient office visits:** $20 Copay per visit 70% of Allowed Amount not subject to Deductible **All other outpatient services, except Medical Emergency Expenses and Prescription Drugs:** Allowed Amount after Deductible
Substance Use Disorder Treatment See also Benefits for Mental Illness and Substance Use Disorder	**Inpatient:** $250 Copay per Hospital Confinement Allowed Amount after Deductible **Outpatient office visits:** $20 Copay per visit 100% of Allowed Amount not subject to Deductible **All other outpatient services, except Medical Emergency Expenses and Prescription Drugs:** Allowed Amount after Deductible	**Inpatient:** $250 Copay per Hospital Confinement Allowed Amount after Deductible **Outpatient office visits:** $20 Copay per visit 70% of Allowed Amount not subject to Deductible **All other outpatient services, except Medical Emergency Expenses and Prescription Drugs:** Allowed Amount 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 Allowed Amount	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

Other	Preferred Provider Benefits	Out-of-Network Provider Benefits
Home Health Care 100 visits maximum per Policy Year Limits do not apply to services provided for Mental Illness or Substance Use Disorders.	Allowed Amount after Deductible	Allowed Amount after Deductible
Hospice Care See Benefits for Hospice Care	Paid as any other Sickness	Paid as any other Sickness
Inpatient Rehabilitation Facility	Allowed Amount after Deductible	Allowed Amount after Deductible
Skilled Nursing Facility	Allowed Amount after Deductible	Allowed Amount after Deductible
Urgent Care Center	$20 Copay per visit 100% of Allowed Amount not subject to Deductible	$20 Copay per visit 70% of Allowed Amount not subject to Deductible
Hospital Outpatient Facility or Clinic	Allowed Amount after Deductible	Allowed Amount 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 See also Benefits for Formula and Enteral Nutrition Products	Allowed Amount after Deductible	Allowed Amount after Deductible
Medical Supplies Benefits are limited to a 31-day supply per purchase.	Allowed Amount after Deductible	Allowed Amount after Deductible
Oral and Maxillofacial Surgery	Paid as any other Sickness	Paid as any other Sickness
Ostomy Supplies	Allowed Amount after Deductible	Allowed Amount after Deductible
Reconstructive Procedures	Paid as any other Sickness	Paid as any other Sickness
Prosthetic Devices	80% of Allowed Amount after Deductible	80% of Allowed Amount after Deductible
Sleep Disorders	Paid as any other Sickness	Paid as any other Sickness
Sterilization	Paid as any other Sickness	Paid as any other Sickness
TMJ Disorders	Paid as any other Sickness	Paid as any other Sickness
Vision Correction	Allowed Amount after Deductible	Allowed Amount after Deductible
Wigs	Allowed Amount after Deductible	Allowed Amount 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.**	Allowed Amount after Deductible	Allowed Amount after Deductible

Other	Preferred Provider Benefits	Out-of-Network Provider Benefits
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 Allowed Amount after Deductible	80% of Allowed Amount after Deductible