THE REGENTS OF THE UNIVERSITY OF MICHIGAN
SCHEDULE OF MEDICAL BENEFITS
Exclusive Provider Organization (EPO) – Michigan Nurses Association Plan
Effective Date: January 1, 2027
Benefit Year: The 12-month period beginning each January 1 and ending each December 31.

EPO Benefits are provided or coordinated by your primary care provider ("PCP") or provided by a participating provider for office services. Services may require prior certification with the Benefit Administrator (except in a medical emergency). For a directory of Priority Health participating providers, call the Customer Service Department at **888-216-6090**. For access to the Find a Doctor tool and other plan and resource information, visit the Priority Health website at priorityhealth.com/umich.

Prior Certification: Prior certification is required for all inpatient hospital or facility services. Providers must access the Priority Health provider portal to prior certify services. You do not need prior certification from the Benefit Administrator for hospital stays for a mother and her newborn of up to 48 hours following a vaginal delivery and 96 hours following a cesarean section. Other services requiring prior certification are:

- Skilled Nursing, Sub acute & Long-term Acute Facility Care
- Inpatient Rehabilitation Care
- Durable Medical Equipment over $1,000
- Clinical Trials (all stages) for Cancer or a Life-threatening Illness/Condition
- Transplants
- Advanced Diagnostic Imaging Services
- Prosthetic Devices over $1,000
- Certain Surgeries and Treatments

The full list of services that require prior certification is included in the Plan Document and Summary Plan Description (PDSPD) and may be updated from time to time. A current listing is also available by calling the Priority Health Customer Service Department at **888-216-6090**. Other services may be prior certified by your provider or you to determine medical/clinical necessity before treatment. Prior certification is not a guarantee of coverage or a final determination of benefits under this Plan.

If you are receiving intensive treatment for mental health services, including inpatient hospitalization and partial hospitalization, your PCP or provider must notify the Behavioral Health Department as soon as possible at **616-464-8500** or **800-673-8043**.

The following information is provided as a summary of benefits available under your plan. This summary is not intended as a substitute for your PDSPD. It is not a binding contract. Limitations and exclusions apply to benefits listed below. A complete listing of covered services, limitations and exclusions is contained in the PDSPD and any applicable amendments to the Plan.

BENEFITS	
Deductibles	Not applicable.
Out-of-Pocket Limits (Includes coinsurance and copayment expenses.)	$3,000 per individual; $6,000 per family per benefit year.
BENEFITS	
Preventive Health Care Services - Preventive Health Care Services are described in Priority Health's Preventive Health Care Guidelines available online at priorityhealth.com/umich or you may request a copy from the Customer Service Department. Priority Health's Guidelines include preventive services required by legislation. The list below also includes procedures approved by your Employer in addition to those included in the Priority Health Guidelines.	
Routine Adult Physical Exams, Screening and Counseling	Covered at 100%.
Women's Preventive Health Care Services	Covered at 100%.
Routine Laboratory Tests, Screening and Counseling (Includes additional select lab procedures, ekg and chest x-ray.)	Covered at 100%.
Routine Prostate-Specific Antigen (PSA)	Covered at 100%.
Well Child and Adolescent Care, Screening and Assessments	Covered at 100%.
Immunizations	Covered at 100%.

BENEFITS	
Medical Office Services	
Your Primary Care Provider (PCP) -Office Visit (Your selected or assigned PCP and/or PCP Practice.) (Face-to-face and telehealth visits.)	$20 copayment per visit.
Retail Health Clinic Visits	$20 copayment per visit.
Specialists and Providers Other Than Your PCP and/or PCP Practice - Office Visits (Face-to-face and telehealth visits.)	$20 copayment per visit.
Gender Affirming Care – Office Visits (Face-to-face and telehealth visits.)	$20 copayment per visit.
Office Surgery	Included in the office visit benefit listed above.
Office Injections	Included in the office visit benefit listed above.
Allergy Injections	Included in the office visit benefit listed above.
Allergy Testing and Serum	Included in the office visit benefit listed above.
Hyaluronic Acid Injections (Limitations apply.)	Included in the office visit benefit listed above.
Diagnostic Radiology and Lab Services (Performed in physician's office.)	Included in the office visit benefit listed above.
Advanced Diagnostic Imaging Services (Includes MRI, CAT Scans, PET Scans, CT/CTA and Nuclear Cardiac Studies.) (Performed in physician's office or freestanding facility.) Prior certification required.	Covered at 100%.
Education Services (Other than as provided in Priority Health's Preventive Health Care Guidelines.)	$20 copayment per visit.
Hospital Services	
Inpatient Hospital and Inpatient Longterm Acute Care Services Prior certification is required except in emergencies or for hospital stays for a mother and her newborn of up to 48 hours following a vaginal delivery and 96 hours following a cesarean section.	Covered at 100%.
Inpatient Professional and Surgical Charges	Covered at 100%.
Gender Affirming Surgical Services Prior certification required.	Covered at 100%.
Human Organ Tissue Transplants Covered only with prior certification from Benefit Administrator.	Covered at 100%.
Approved Clinical Trial Expenses (Routine expenses related to approved clinical trial.)	Covered at 100%.
Outpatient Hospital Care and Observation Care Services (Including ambulatory surgery center facility charges.)	Covered at 100%.
Outpatient Hospital Professional and Surgical Charges	Covered at 100%.
Maternity Services in Hospital (Delivery, facility and anesthesia services.)	Covered at 100%.
Hospital and Freestanding Facility Diagnostic Laboratory & Radiology Services	Covered at 100%.

BENEFITS	
Hospital Services (continued)	
Hospital Advanced Diagnostic Imaging Services (Includes MRI, CAT Scans, PET Scans, CT/CTA and Nuclear Cardiac Studies.) Prior certification required for outpatient services.	Covered at 100%.
Certain Surgeries and Treatments • **Reconstructive Surgery:** blepharoplasty of upper eyelids, breast reduction, panniculectomy, rhinoplasty, septorhinoplasty and surgical treatment of male gynecomastia. • **Varicose Veins Treatments** Prior certification may be required.	Covered at 100%.
Weight Loss Services • Bariatric Surgery • Weight Loss Programs Prior certification required.	$1,000 copayment. Coverage is limited to one bariatric surgery per lifetime unless medically/ clinically necessary.
Medical Emergency and Urgent Care Services	
Observation Care Services	$75 copayment per visit. Reasonable and customary limitations apply for services provided by a non-participating provider.
Note: Service received while in observation will be paid under the hospital services benefits.	
Emergency Room Services	$75 copayment per visit.
Note: If you are admitted for hospital inpatient care from the emergency room, your emergency room charges will be paid under the hospital services benefits and the emergency room services copayment does not apply.	
Ambulance Services	Covered at 100%. Reasonable and customary limitations apply for services provided by a non-participating provider.
Urgent Care Facility Services	$20 copayment per visit.
Behavioral Health Services	
Inpatient Mental Health & Substance Use Disorder Services (Including subacute residential treatment facility and partial hospitalization.) Prior certification required except in emergencies.	Covered at 100%.
Outpatient Mental Health Services (Face-to-face and telehealth visits.)	The first three visits (within 90 days of discharge) from a network hospital for mental health inpatient care are covered at 100%. Visits thereafter apply as noted below. $20 copayment per visit.
Outpatient Substance Use Disorder Services (Face-to-face and telehealth visits.)	$20 copayment per visit.
Family Planning and Reproductive Services	
Obstetrical Services by Physician (Prenatal and postnatal care.)	Covered at 100% under the Preventive Health Care Services benefits above. See the hospital services for facility and physician benefits related to obstetrical services, including delivery and nursery services.
Maternity Education Classes	Attendance at an approved maternity education program is covered at 100%.
Infertility Counseling & Treatment (Covered for diagnosis and treatment of underlying cause only.)	$20 copayment per visit.
Reproductive Services (Services related to induction of pregnancy.) Prior certification required.	Covered at 80% up to a $20,000 lifetime maximum benefit.

BENEFITS	
Family Planning and Reproductive Services (continued)	
Vasectomy	Covered at 100%. Office visit copayment may apply.
Tubal Ligation/Tubal Obstructive Procedures (Included as part of the Women's Preventive Health Services benefits.)	Covered at 100%. If received during an inpatient stay, only the services related to the tubal ligation/tubal obstructive procedures are covered at 100%.
Birth Control Services (Included as part of the Women's Preventive Health Services benefits.) Includes; diaphragms, implantables, injectables, and IUD (insertion and removal), etc.	Covered at 100%.
Elective Abortions	Covered at 100%. Office visit copayment may apply. Limited to 1 procedure per 24 months.
Rehabilitative Medicine Services – Not related to Autism Treatment	
Physical, Occupational and Speech Therapy	$20 copayment up to a maximum of 60 visits per benefit year.
Cardiac Rehabilitation	Covered at 100% up to a maximum of 36 visits per 18 week period. Additional 36 visits per 18 week period if necessary.
Pulmonary Rehabilitation	Covered at 100% up to a maximum of 12 visits per benefit year. Additional 12 visits per benefit year if necessary.
Chiropractic and Osteopathic Manipulation Services (Includes maintenance care.)	$20 copayment up to a maximum of 24 visits per benefit year.
Habilitation Services - Related to the Treatment of Autism Spectrum Disorder	
Physical and Occupational Therapy for the Treatment of Autism Spectrum Disorder	$20 copayment per visit.
Speech Therapy for the Treatment of Autism Spectrum Disorder	$20 copayment per visit.
Applied Behavior Analysis (ABA) for the Treatment of Autism Spectrum Disorder Prior certification required.	$20 copayment per visit.
Other Services	
Durable Medical Equipment Prior certification is required for charges over $1,000.	Covered at 100%.
Prosthetic & Orthotic/Support Devices Prior certification is required for charges over $1,000.	Covered at 100%.
Temporomandibular Joint Dysfunction or Syndrome Treatment	$20 copayment per visit.
Orthognathic Treatment	$20 copayment per visit.
Non-Hospital Facility Services – Including skilled nursing care services received in a: • Skilled Nursing Care Facility • Subacute Facility • Inpatient Rehabilitation Facilities Treatment (Combined maximum for all services.) Prior certification required.	Covered at 100% up to a maximum of 120 days per benefit year.
Hospice Services (Limitations apply.) Prior certification required.	Covered at 100%.
Home Health Services and Infusion Therapy (Excluding rehabilitative medicine.)	Covered at 100%.
Custodial Care/Private Duty Nursing/Home Health Aides	Not covered.
Hearing Exam/Test	$20 copayment once per 36 months.
Hearing Aids (Monaural or binaural)	Covered up to the allowed amount every 36 months.
Refractive Eye Exam	Covered at 100% once per benefit year.

Pharmacy Benefits	
Administered by Prime Therapeutics	For prescription drug benefit information call Prime Therapeutics at: **888-272-1346.**
Coverage Information	
Motor Vehicle Injuries	Coordinated with motor vehicle insurance.
Motorcycle Injuries	Coordinated with motorcycle insurance.

In accordance with the terms and conditions of the PDSPD, you are entitled to covered services when these services are:

A. Medically/clinically necessary; and
B. Not excluded in the PDSPD.

You will be responsible for those services that are beyond those approved, beyond the benefit maximums or excluded from coverage.

You will be responsible for services rendered that are beyond those prior certified as medically/clinically necessary.

If the hospital confinement extends beyond the number of certified days, the additional days will not be covered unless:

- The extension of days is medically/clinically necessary, and
- Prior certification for the extension is obtained before exceeding the number of prior certified days.

The "out-of-pocket limit" is the total amount of coinsurance and copayments for covered services that you will pay during the benefit year**,** except as described below. Amounts paid for any of the following will not apply toward the out-of-pocket limit. You will be responsible for the following expenses even after the out-of-pocket limit has been reached:

- any monies you paid for non-covered services; and
- any monies you paid for covered services that exceed the annual day/visit or dollar benefit maximum for a specific benefit and therefore, denied as non-covered services.

Notwithstanding the above, the following out-of-pocket costs do not apply toward the out-of-pocket limit: Services that exceed the annual day or dollar benefit maximums for a specific benefit (denied as non-covered services).