



mi UFCW
UNIONS AND EMPLOYERS
RETIREE HEALTH PLAN



SUMMARY OF BENEFITS for Retiree Plan

For Eligible Retiree and Spouse Effective 7/1/2020

In-Network services percentage refers to percentage of Preferred Provider Organizations contracted amount. Out-of-Network percentage refers to percentage of Usual, Customary and Reasonable charges.

Medical Benefits		
Lifetime Maximum for Medical Benefits	\$250,000 per individual	
Calendar Year Deductible	\$500 per individual	
Benefit	In-Network Provider	Out-of-Network Provider
Calendar Year Out-of-Pocket Maximum (per individual)	\$5,000 (includes deductible)	\$15,000 (includes deductible)
Medical Benefits	Plan pays 80% after deductible	Plan pays 60% after deductible
Age Appropriate Preventive/Routine/Wellness	100% of covered expense, (no copay, deductible or co-insurance)	60% after deductible
Office Visits	Covered 100% after \$20 Co-pay	60% after deductible
Specialist Office Visits	Covered 100% after \$30 Co-pay	60% after deductible
Urgent Care Facility (free-standing only)	Covered 100% after \$40 Co-pay	60% after deductible
Emergency Room Treatment Due to Illness	\$100 Co-pay if not admitted to the Hospital, then 80% after deductible	\$100 Co-pay if not admitted to the Hospital, then 60% after deductible
Surgical Benefits Allowable Amounts: All covered surgical procedures	Plan pays 80% of allowable amount after deductible	Plan pays 60% of allowable amount after deductible
1st Procedure	100%	100%
2nd Procedure	50%	50%
Chiropractic Benefits	Covered 100% after \$30 Co-pay	Plan pays 60% after deductible
Office Visit	Other covered expenses payable at 80% after deductible	
	X-rays limited to 1 set per calendar year	X-rays limited to 1 set per calendar year
Annual Maximum	\$1,500	\$1,500
Podiatry Benefit	Plan pays 80% after deductible	Plan pays 60% after deductible
Calendar Year Maximum	\$1,500	\$1,500

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Benefit	In-Network Provider	Out-of-Network Provider
Substance Abuse Benefits Inpatient & Outpatient	Covered 100% after \$20 co-pay after deductible	Plan pays 60% after deductible
Mental/Nervous Disorder Benefits Office Visit	Covered 100% after \$20 Co-pay Other covered expenses payable at 80% after deductible	60% after deductible
Inpatient & Outpatient	80% for up to 20 visits per calendar year after deductible	60% for up to 20 visits per calendar year after deductible
Prescription Drug Benefits		
Prescription Drug Calendar Year Deductible	\$100 per individual	N/A
Prescription Drug Calendar Year Maximum Benefit	\$5,000 per individual	N/A
Retail Co-Payment Percentage (After Prescription Drug Deductible)	20% up to \$50 maximum out-of-pocket expense per drug per fill or refill when filled at a participating pharmacy	N/A
Mail Order Co-Payment Percentage (After Prescription Drug Deductible)	20% up to \$125 maximum out-of-pocket expense per drug per 90 day fill or refill when filled under Mail Order Program	N/A
Dental & Vision Benefits		
Vision Benefits	Up to \$35, once every 12 months for exam Up to \$100, once every 24 months for frames/lenses/contact lenses	
Delta Dental of Michigan	100% for Preventive Dental Services, such as Periodic Oral Exams, Dental x-rays and Prophylaxis (cleaning)	
	80% up to \$2,000 per calendar year for non-preventive services	
Orthodontia (\$2,000 lifetime maximum)	Orthodontia- 50% of dental fee schedule	

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