

2024 COMPARISON CHART

RETIREE GROUP HEALTH PROGRAM

The chart below compares the Retiree Group Health Program and Prescription Drug Program options for 2024. You can verify your eligibility for these options at rrd.bswift.com or contact the Benefits Center at **1-877-RRD-4BEN (1-877-773-4236)**, Monday through Friday, 7 a.m. to 7 p.m. CT.

PROGRAM/BENEFIT	UHC POST-65 RETIREE MEDICARE	UHC PRE-65 RETIREE VALUE		UHC PRE-65 RETIREE PPO	
Medical	UHC Member Services 1-866-868-0286 UHCRetiree.com	UHC Member Services 1-877-442-5999 uhc.com			
		<i>In-Network</i>	<i>Out-of-Network</i>	<i>In-Network</i>	<i>Out-of-Network</i>
Annual Deductible*	\$400	\$2,000/individual \$4,000/family Combined Medical & Pharmacy		\$500/individual \$1,000/family	\$1,000/individual \$2,000/family
Annual Out-of-Pocket Maximum*	\$2,000/individual	\$4,500/individual \$9,000/family Combined Medical & Pharmacy		\$2,500/individual \$5,000/family	\$3,000/individual \$6,000/family
Lifetime Maximum	NA	\$2,000,000 combined with Out-of-Network		\$2,000,000 combined with Out-of-Network	
Coinsurance Percentage	80% or 90%, varies by service	80%	60%	80%	60%
Preventive Care	\$0 copay	100% covered with no deductible	60% covered after deductible	100% covered with no deductible	60% covered after deductible
Physician Office Visits	<ul style="list-style-type: none"> PCP: \$10 copay Specialist: \$20 copay 	80% covered after deductible	60% covered after deductible	80% covered after deductible	60% covered after deductible
Inpatient Hospital Services	\$150 copay	80% covered after deductible	60% covered after deductible	80% covered after deductible	60% covered after deductible
Inpatient/Outpatient Professional Services	80% covered after deductible**	80% covered after deductible	60% covered after deductible	80% covered after deductible	60% covered after deductible
Outpatient Lab/X-ray	80% covered after deductible	80% covered after deductible	60% covered after deductible	80% covered after deductible	60% covered after deductible
Outpatient Surgery	90% covered after deductible	80% covered after deductible	60% covered after deductible	80% covered after deductible	60% covered after deductible
Emergency Room/ Urgent Care Facility	<ul style="list-style-type: none"> Emergency Room: \$65 copay Urgent Care Facility: \$35 copay 	80% covered after deductible	80% covered after deductible, if claims administrator determines true emergency; otherwise, 60% covered after deductible	80% covered after deductible	80% covered after deductible, if claims administrator determines true emergency; otherwise, 60% covered after deductible

PROGRAM/BENEFIT	UHC POST-65 RETIREE MEDICARE	UHC PRE-65 RETIREE VALUE		UHC PRE-65 RETIREE PPO	
		In-Network	Out-of-Network	In-Network	Out-of-Network
Outpatient Rehabilitation Services <i>Limited to a maximum of 90 visits per year combined with Physical, Occupational, Pulmonary, Cognitive and Speech Therapies</i>	<ul style="list-style-type: none"> PT/OT/ST: 90% covered after deductible Cardiac/Pulmonary: 90% covered after deductible Chiropractic: \$20 copay 	80% covered after deductible	60% covered after deductible	80% covered after deductible	60% covered after deductible
Mental Health and Substance Abuse	<ul style="list-style-type: none"> Inpatient: \$150 copay Outpatient: \$20 copay 	80% covered after deductible	60% covered after deductible	80% covered after deductible	60% covered after deductible

* **Pre-65 Retiree Value option:** If you cover dependents, the Plan starts paying benefits for an individual's claims only after the *total* family deductible has been met, even if those expenses are incurred by only one individual. Similarly, the Plan starts paying 100% only after the *total* family out-of-pocket maximum has been met, even if those expenses are incurred by only one individual.

** Please refer to the Annual Notice of Change that was mailed to you by UHC.

Charges above usual and customary (U&C) limits are member's responsibility. Amounts above U&C don't count toward the annual deductible or the out-of-pocket maximum.

PROGRAM/BENEFIT	UHC POST-65 RETIREE MEDICARE	UHC PRE-65 RETIREE VALUE		UHC PRE-65 RETIREE PPO	
		In-Network	Out-of-Network	In-Network	Out-of-Network
Prescription Drug	SilverScript® (Employer PDP) 1-855-313-9445 or TTY 711, 24/7 caremark.com	CVS Caremark 1-866-273-8402 caremark.com			
Retail 30-day supply	<p>If you're currently enrolled, you'll receive the following from SilverScript prior to Annual Enrollment: Annual Notice of Change, Evidence of Coverage, Pharmacy Directory, Abridged Formulary</p> <p>If you're newly enrolling, you'll receive the following once you are enrolled: Summary of Medicare Part D Benefits; Opt Out Notice (do not opt out of SilverScript if you wish to retain retiree medical coverage through RRD); Evidence of Coverage; Pharmacy Directory; Abridged Formulary</p>	<i>In-Network</i>	<i>Out-of-Network</i>	<i>In-Network</i>	<i>Out-of-Network</i>
<ul style="list-style-type: none"> Tier 1 Generic 		80% covered after deductible	60% covered after deductible	80% covered; \$10 minimum copay	
<ul style="list-style-type: none"> Tier 2 Brand formulary 		80% covered after deductible	60% covered after deductible	60% covered; \$10 minimum copay	
<ul style="list-style-type: none"> Tier 3 Brand non-formulary 		80% covered after deductible	60% covered after deductible	50% covered; \$10 minimum copay	
Mail-order 90-day supply		80% covered after deductible		80% covered; \$30 minimum copay	
<ul style="list-style-type: none"> Tier 1 Generic 		80% covered after deductible		60% covered; \$30 minimum copay	
<ul style="list-style-type: none"> Tier 2 Brand formulary 		80% covered after deductible		50% covered; \$30 minimum copay	
<ul style="list-style-type: none"> Tier 3 Brand non-formulary 					
Annual Prescription Drug Out-of-Pocket Maximum	After you reach the annual out-of-pocket maximum, (\$2,500/individual or \$4,500/family), RRD will pay your prescription drug costs for the remainder of the plan year	Combined with Medical		\$2,500/individual \$4,500/family	