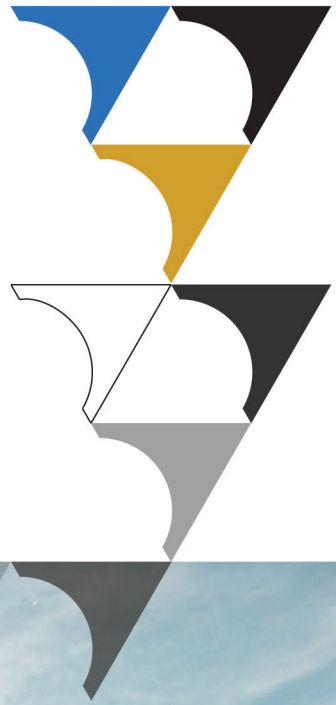


EMPOWERED TO THRIVE



2026 Benefits Guide Retirees





Introduction

Preparing for retirement is a significant milestone. We are committed to supporting our employees in making informed decisions and planning for a secure retirement. This guide is designed to provide information and resources to help navigate the transition from active employment to retirement. It is intended as a general summary, and every effort has been made to report information accurately.

A more complete summary of benefits and the terms under which they are provided, including limitations and exclusions, are contained in the plan documents. If there are any discrepancies between information contained in this guide and the plan documents, the plan documents are the controlling documents. The company reserves the right to modify or terminate the plans described in this guide at any time without notice.

Eligibility

All regular full-time employees who are at least age 55 with a minimum of five (5) years of service are eligible for retirement if age plus years of service equals 65 or more.

Understanding Your Retirement Benefits

Benefits You Can Continue

- **Retiree Healthcare:** You may choose between Retiree Health Access (RHA) plans through Aetna and COBRA continuation coverage administered by WEX.
- **Dental & Vision:** You may continue your current dental and vision coverage. You will receive payment instructions and coupons in the mail from WEX.
- **Life Insurance:** Coverage will terminate at midnight of your retirement date; however, you may convert or port your coverage by contacting Securian within 30 days of your retirement date.
- **Legal Plan:** You may continue your access to the legal plan by paying ARAG directly.
- **BMI Federal Credit Union:** If you have an account, you have a lifetime membership.
- **Barbershop:** Access is available during regular hours and appointments must be made in advance.
- **Medical Center & Pharmacy:** You may continue to use the Medical Center and Pharmacy. If you have other health insurance, you may need to pay out-of-pocket and then submit a claim to your healthcare provider for reimbursement.
- **Columbus Fitness Center:** Access is available during regular hours. Monthly payments can be made by cash or check.
- **Health Fair:** An annual Health Fair is typically held in late October in our central Ohio locations. Be sure to notify us if your contact information changes after you retire.



Discontinued Benefits

- **Worthington Enterprises Healthcare:** Your coverage will continue through the end of the month when you retire. If you are enrolled in the HRA plan, any unused amount in your fund will be forfeited.
- **Health Savings Account:** You may keep your HealthEquity HSA; however, your account will no longer be affiliated with Worthington Enterprises and monthly maintenance fees may apply.
- **Employee Assistance Program (EAP):** You have access for 30 days after your retirement date.
- **Flexible Spending Accounts (FSA):** Claims for eligible expenses incurred through your retirement date may be submitted until May 31 of the following calendar year.
- **Salary Plan:** Coverage terminates on your retirement date.
- **Disability Insurance:** Coverage terminates on your retirement date.
- **Tuition Reimbursement:** Coverage terminates on your retirement date. Any previously approved reimbursement requests that have not been paid are revoked.
- **Stock Purchase Plan:** Your account will not automatically close; although, your participation will be discontinued after the last regular and/or supplemental check. Contact Broadridge to discuss your options.
- **Stock Options:** Any unvested stock options will be discontinued as of your retirement date. You may exercise vested options at any time before the earliest 36 months from your retirement date or the expiration date specified in your grant agreement. For questions, contact stockadministration@wthg.com.
- **Restricted Stock:** Any unvested restricted stock will vest as of your retirement date on a prorated basis based on the number of full months since the date of the grant. For questions, contact stockadministration@wthg.com.



Retiree Healthcare Options

Option	Ages 55-64	Age 65 or Older
COBRA	You and/or dependents may continue for up to 18 months.	Not recommended: COBRA is secondary to Medicare
Aetna RHA Pre-65 Plans	You and/or dependents may enroll: <ol style="list-style-type: none"> 1. upon retirement 2. after 18 months of COBRA 3. via a life event 4. during RHAs annual open enrollment 	Not Eligible
Aetna RHA Medicare Plans	Not Eligible	You and/or dependents may enroll: <ol style="list-style-type: none"> 1. upon retirement 2. via a life event 3. upon reaching Medicare eligibility 4. during RHAs annual open enrollment

Medicare Choice Group

It's important to understand your healthcare options as you approach Medicare eligibility. We are partnering with Medicare Choice Group to provide free Medicare education and enrollment services. Medicare Choice Group provides one-on-one, unbiased advice, practical decision support and coverage options based on your specific needs. See the enclosed flyer for more information.

Aetna RHA Plans

We have joined with other leading employers, in partnership with Aetna, to offer Retiree Health Access plans.

If you are under age 65, you will be able to choose between high and low-deductible RHA health plans. Your benefits may be retroactive to your retirement date. See the Pre-65 Benefit Summary in the appendix for plan details and costs.

If you are at least age 65, you are eligible for the RHA Medicare Plan. This is a Medicare Advantage Plan (Medicare Part C) that includes prescription drugs, with one medical and pharmacy ID card. You are also required to sign up for Medicare parts A&B. See the Medicare fact sheet in the appendix. If you elect this plan, your coverage will start the first of the month following the month in which you enroll. See the PPO Plan Summary in the appendix for plan details.



To review the RHA plans prior to retirement, contact the RHA service center. The service center representatives can review the information by phone, and they can set up a personalized login to allow you to view the plan options and costs online. You will be able to see plans that are available based on zip code and Medicare availability.

To enroll immediately upon retirement, you must register on the RHA website or call within 90 days of your retirement date. Please note that it takes 5-10 business days for RHA to receive your retirement information, and you will not be able to register until that time.

COBRA

If you choose, you can continue your existing healthcare coverage by electing COBRA for up to 18 months from your retirement date. A COBRA notice will be mailed to you by WEX.

You have 60 days from the date you receive the COBRA notice to sign up for COBRA coverage. If you choose COBRA coverage, your benefits will continue at the full COBRA premium rate retroactive to the first of the month following your retirement date. After you elect COBRA, WEX will mail payment coupons to you.

Note: COBRA participants are not eligible for company HSA contributions. If you become entitled to Medicare less than 18 months prior to your retirement, COBRA coverage for dependents may be extended for up to 36 months after the date of your Medicare entitlement.

Monthly COBRA Rates

Plan Type	Plan Name	EE Only	EE + Child(ren)	EE + Spouse	EE + Family
Medical	HSA Select Plan	\$749.58	\$1,329.14	\$1,669.16	\$2,349.18
Medical	HSA Choice Plan	\$700.57	\$1,245.41	\$1,556.82	\$2,179.61
Medical	HRA Select Plan	\$825.64	\$1,486.22	\$1,816.44	\$2,477.01
Medical	HRA Choice Plan	\$756.12	\$1,360.61	\$1,662.89	\$2,267.61
Dental	Premium Plan	\$26.16	\$65.23	\$49.71	\$99.09
Dental	Value Plan	\$17.60	\$48.12	\$32.96	\$71.85
Vision	Premium Plan	\$13.70	\$23.01	\$19.43	\$36.79
Vision	Value Plan	\$9.79	\$16.47	\$13.91	\$26.34



401(k) and Payroll

401(k)

Your retirement account is 100% vested and includes your own voluntary contributions as well as the company match (50% up to 4%) and the company-provided deferred profit sharing (3% of eligible wages). Our plan offers a 59 ½ withdrawal that permits active employees to take a distribution or rollover of employee and match contributions after age 59 ½.

You will continue to receive your voluntary and company contributions through your last regular pay and/or supplemental pay.

If you have an outstanding Fidelity loan, you have 90 days from your retirement date to pay off your loan or to set up ACH payments with Fidelity. If the loan is not paid in full, you will be taxed on the remaining balance. You may also have to pay a tax penalty.

After your retirement date, please call Fidelity to discuss your distribution options. Options will vary based on your age and your account balance.

Vacation

You are eligible to receive payment for any unused vacation. To qualify, you must work at least the number of days/weeks of eligible vacation into the year to receive your full unused vacation allotment. You can select one of two options:

1. You can receive a lump sum payment in your last paycheck. For example, if you have 10 days of unused vacation remaining when you retire, you will receive payment for 80 hours of vacation.
2. You can use the remaining vacation days to delay the beginning of your retirement. If you have 10 days of unused vacation remaining when you retire, your official retirement date will be 10 business days after your last day worked. If you choose this option, you will not be able to access your Fidelity accounts until after your official retirement date.

Profit Sharing/Supplemental Pay

You will be paid profit sharing for your last quarter worked through your official retirement date. Your profit sharing or bonus check will be paid on the next regularly scheduled profit sharing/supplemental pay date.

Final Paycheck

Your last paycheck will be paid to you on the next regularly scheduled pay date through the same method as your prior checks.



Resources and Support

Please contact your HR Business Partner to discuss your retirement plans.

Benefit Plan	Vendor	Phone	Website
COBRA	WEX	877.837.5017	www.mypremiumbill.com
Worthington Medical Plans	Anthem	833.824.2292	www.anthem.com
Retiree Health Access	Aetna	800.426.4584	www.retireehealthaccess.net/worthington
Medicare Education	Medicare Choice Group	855.626.7127	www.visit.medicarechoicegroup.com/worthington
Spending Accounts	HealthEquity	866.346.5800	https://my.healthequity.com
Dental	Delta Dental	800.524.0149	www.deltadentaloh.com
Vision	VSP	800.877.7195	www.vsp.com
Life Insurance	Securian	866.293.6047	www.securian.com
EAP	SupportLinc	888.881.5462	www.supportlinc.com (Code: Worthington)
401(k)	Fidelity	800.835.5091	www.401k.com
Legal Plan	ARAG	800.247.4184	www.members.araggroup.com/sglcp
Employee Stock	Broadridge	844.943.0717	shareholder.broadridge.com/wor
Worthington's People Center		877.840.6506	wpc@wthg.com

We wish you all the best as you embark on this exciting new chapter!

Medicare & Beyond

Medicare and Individual Health Enrollment services for any stage of your life!



Explore Your Path To Medicare.

Whether you're retiring, actively working, or have a loved one turning 65, we'll guide you through each step of your Medicare journey.

Step 1

Schedule your free one-on-one consultation.

Step 2

Explore your options with a certified Medicare advisor.

Step 3

Plan your Medicare transition with a Medicare advisor.

Step 4

Enroll in Medicare with step-by-step guidance and decision support.

Medicare Choice Group is your trusted partner for Medicare and Individual Health.

<https://visit.medicarechoicegroup.com/worthington>

Schedule your free consultation today.



Get started!
Scan to learn more.
855-626-7127



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Aetna MedicareSM Plan (PPO)
MA (S02) PPO
Rx RHA R-3

Benefits and Premiums are effective January 1, 2026 through December 31, 2026

SUMMARY OF BENEFITS
PROVIDED BY AETNA LIFE INSURANCE COMPANY

Primary Care Physician (PCP): You have the option to choose a PCP. When we know who your provider is, we can better support your care.

Referrals: Your plan doesn't require a referral from a PCP to see a specialist. Keep in mind, some providers may require a recommendation or treatment plan from your doctor in order to see you.

Prior Authorizations: Your doctor will work with us to get approval before you receive certain services or drugs. Benefits that may require a prior authorization are listed with an asterisk (*) in the benefits grid.

PLAN FEATURES	This is what you pay for network providers.	This is what you pay for out-of-network providers.
Monthly Premium	Please contact the Aetna Retiree Service Center for more information on your plan premium.	
Plan Follows the Federal Medicare Part B Deductible	No	
Plan deductible is equal to the Federal Medicare Part B deductible		
Annual Deductible	\$200	\$400

This is the amount you have to pay out of pocket before the plan will pay its share for your covered Medicare Part A and B services.

Services Exempt from Deductible:

Annual wellness exams, routine physical exam, routine mammograms, diagnostic mammogram, routine hearing exam, routine colorectal screening, routine prostate screening, bone mass measurement, immunization, routine GYN, routine eye care, kidney disease education, Medicare diabetic prevention program (MDPP), Medicare-covered \$0 preventive services, additional Medicare preventive care services, Part B Drugs - Insulin, Continuous Glucose Monitors (CGMs), emergency room, emergency ambulance services, some Medicare-covered diagnostic tests and labs (Urine protein, Prothrombin testing, HBA1C, FIT Screening, Fundus Testing, gFOBT Testing and COVID lab tests), Wigs, Teladoc, and urgently needed care.

Out-of-network services exempt from Deductible:



Annual wellness exams, routine physical exam, routine mammograms, routine hearing exam, routine colorectal screening, routine prostate screening, bone mass measurement, immunization, routine GYN, routine eye care, kidney disease education, Medicare diabetic prevention program (MDPP), Medicare-covered \$0 preventive services, additional Medicare preventive care services, emergency room, emergency ambulance services, Part B Drugs - Insulin, Wigs, and urgently needed care.

Annual Maximum Out-of-Pocket Amount	Network Services:	Network and out-of-network services:
Annual maximum out-of-pocket limit amount includes any deductible, copayment or coinsurance that you pay.	\$4,201	\$8,950 for in and out-of-network services combined

It will apply to all medical expenses except Hearing Aid Reimbursement , Vision Reimbursement and Medicare prescription drug coverage that may be available on your plan.

HOSPITAL CARE*	This is what you pay for network providers.	This is what you pay for out-of-network providers.
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Inpatient Hospital Care	\$250 per stay	25% per stay
The member cost sharing applies to covered benefits incurred during a member's inpatient stay.		

Observation Stay	Your cost share for Observation Care is based upon the services you receive	Your cost share for Observation Care is based upon the services you receive
Frequency:	per stay	per stay

Outpatient Services & Surgery	\$0	25%
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Ambulatory Surgery Center	\$0	25%
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PHYSICIAN SERVICES	This is what you pay for network providers.	This is what you pay for out-of-network providers.
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Primary Care Physician Visits	\$25	25%
Includes services of an internist, general physician, family practitioner for routine care as well as diagnosis and treatment of an illness or injury and in-office surgery.		

Physician Specialist Visits	\$25	25%
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PREVENTIVE CARE	This is what you pay for network providers.	This is what you pay for out-of-network providers.
Medicare-covered Preventive Services <ul style="list-style-type: none">• Abdominal aortic aneurysm screenings• Alcohol misuse screenings and counseling• Annual Well Visit - One exam every 12 months.• Bone mass measurements• Breast exams• Breast cancer screening: mammogram - one baseline mammogram for members age 35-39; and one annual mammogram for members age 40 & over.• Cardiovascular behavior therapy• Cardiovascular disease screenings• Cervical and vaginal cancer screenings (Pap) - one routine GYN visit and pap smear every 24 months.• Colorectal cancer screenings (colonoscopy, fecal occult blood test, flexible sigmoidoscopy)• Depression screenings• Diabetes screenings• HBV infection screening• Hepatitis C screening tests• HIV screenings• Lung cancer screenings and counseling• Nutrition therapy services• Obesity behavior therapy• Pelvic Exams and pap test (screening) - one routine GYN visit and pap smear every 24 months.• Prolonged Preventive Services - prolonged preventive service(s) (beyond the typical service time of the primary procedure), in the office or other outpatient setting requiring direct patient contact beyond the usual service• Prostate cancer screenings (PSA) - for all male patients aged 50 and older (coverage begins the day after 50th birthday)• Sexually transmitted infections screenings and counseling• Tobacco use cessation counseling• Welcome to Medicare preventive visit	\$0	25%
Medicare-covered Preventive Services (continued)		



• Medicare Diabetes Prevention Program - 12 months of core session for program eligible members with an indication of pre-diabetes.

\$0

\$0

Immunizations

\$0

\$0

- Flu
- Hepatitis B
- Pneumococcal

Additional Medicare Preventive Services

\$0

25%

- Barium enema
- Diabetes self-management training (DSMT)
- Digital rectal exam (DRE)
- EKG following welcome exam
- Glaucoma screening

EMERGENCY AND URGENT MEDICAL CARE

This is what you pay
for network providers.

This is what you pay for
out-of-network
providers.

Emergency Care; Worldwide
(waived if admitted)

\$95

\$95

Urgently Needed Care; Worldwide

\$25

\$25

DIAGNOSTIC PROCEDURES*

This is what you pay
for network providers.

This is what you pay for
out-of-network
providers.

Diagnostic Radiology

\$25

25%

CT scans

Diagnostic Radiology

\$25

25%

Other than CT scans

Lab Services

\$25

25%

Diagnostic testing & procedures

\$25

25%

Outpatient X-rays

\$25

25%



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HEARING SERVICES	This is what you pay for network providers.	This is what you pay for out-of-network providers.
Routine Hearing Screening We cover one exam every twelve months	\$0	25%
Medicare Covered Hearing Examination	\$25	25%
Hearing Aid Reimbursement	\$1,000 once every 36 months	
DENTAL SERVICES	This is what you pay for network providers.	This is what you pay for out-of-network providers.
Medicare Covered Dental* Non-routine care covered by Medicare.	\$25	25%
VISION SERVICES	This is what you pay for network providers.	This is what you pay for out-of-network providers.
Routine Eye Exams One annual exam every 12 months.	\$0	25%
Diabetic Eye Exams	\$0	25%
Medicare Covered Eye Exam	\$25	25%
Vision Eyewear Reimbursement Applies to in or out of network	\$100 once every 24 months	



MENTAL HEALTH SERVICES*	This is what you pay for network providers.	This is what you pay for out-of-network providers.
Inpatient Mental Health Care The member cost sharing applies to covered benefits incurred during a member's inpatient stay.	\$250 per stay	25% per stay
Outpatient Mental Health Care Individual visit	\$25	25%
Partial Hospitalization and Intensive Outpatient Services	\$25	25%
Inpatient Substance Abuse The member cost sharing applies to covered benefits incurred during a member's inpatient stay.	\$250 per stay	25% per stay
Outpatient Substance Abuse Individual visit	\$25	25%
SKILLED NURSING SERVICES*	This is what you pay for network providers.	This is what you pay for out-of-network providers.
Skilled Nursing Facility (SNF) Care Limited to 100 days per Medicare Benefit Period. The member cost sharing applies to covered benefits incurred during a member's inpatient stay. A benefit period begins the day you go into a hospital or skilled nursing facility. The benefit period ends when you haven't received any inpatient hospital care (or skilled care in a SNF) for 60 days in a row. If you go into a hospital or a skilled nursing facility after one benefit period has ended, a new benefit period begins. There is no limit to the number of benefit periods.	\$0 per day, days 1-20; \$100 per day, days 21-100	25% per day, days 1-100
PHYSICAL THERAPY SERVICES*	This is what you pay for network providers.	This is what you pay for out-of-network providers.
Outpatient Rehabilitation Services (Speech, physical, and occupational therapy)	\$25	25%



AMBULANCE SERVICES	This is what you pay for network providers.	This is what you pay for out-of-network providers.
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Ambulance Services

\$25

25%

Prior authorization rules may apply for non-emergency transportation services received in-network. Your network provider is responsible for requesting prior authorization. Our plan recommends pre-authorization of non-emergency transportation services when provided by an out-of-network provider.

TRANSPORTATION SERVICES	This is what you pay for network providers.	This is what you pay for out-of-network providers.
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Transportation (non-emergency)

24 one-way trips with 60 miles allowed per trip

MEDICARE PART B PRESCRIPTION DRUGS*	This is what you pay for network providers.	This is what you pay for out-of-network providers.
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Medicare Part B Prescription Drugs

20%

25%

Medicare Part B Prescription Drugs - Insulin

20% up to \$35

20% up to \$35

MEDICARE PART D PRESCRIPTION DRUGS	This is what you pay for network providers.	This is what you pay for out-of-network providers.
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Part D drugs are covered. See PHARMACY - PRESCRIPTION DRUG BENEFITS section below for your plan benefits at each part D stage, including cost share and other important pharmacy benefit information.



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ADDITIONAL PROGRAMS AND SERVICES	This is what you pay for network providers.	This is what you pay for out-of-network providers.
Allergy Shots	20%	25%
Allergy Testing	\$25	25%
Blood	\$0	25%
All components of blood are covered beginning with the first pint.		
Cardiac Rehabilitation Services	\$25	25%
Intensive Cardiac Rehabilitation Services	\$25	25%
Chiropractic Services*	\$15	25%
Medicare covered benefits only.		
Diabetic Supplies*	\$0	25%
Includes supplies to monitor your blood glucose from LifeScan.		
Durable Medical Equipment/ Prosthetic Devices*	20%	25%
Home Health Agency Care*	\$0	25%
Hospice Care	Covered by Original Medicare at a Medicare certified hospice.	
Medical Supplies*	Your cost share is based upon the provider of services	Your cost share is based upon the provider of services
Medicare Covered Acupuncture	\$25	25%
Outpatient Dialysis Treatments*	\$25	\$25
Podiatry Services	\$25	25%
Medicare covered benefits only.		
Pulmonary Rehabilitation Services	\$15	25%
Supervised Exercise Therapy (SET) for PAD Services	\$15	25%
Radiation Therapy*	\$25	25%
ADDITIONAL PROGRAMS (NOT COVERED BY ORIGINAL MEDICARE)	This is what you pay for network providers.	This is what you pay for out-of-network providers.
Healthy Rewards	Covered	



Meals	\$0	
Covered up to 14 meals following an inpatient stay.		
Resources For Living[®]	Covered	
For help locating resources for every day needs.		
Smoking and Tobacco Use Cessation Supplies	\$0	25%
Frequency	unlimited visits every year	unlimited visits every year
Teladoc[™]	\$0	
Telemedicine services with a Teladoc [™] provider. State mandates may apply.		
Telehealth	Covered	
Telemedicine Services. Member cost share will apply based on services rendered.		
Telehealth PCP	\$25	25%
Telehealth Specialist	\$25	25%
Telehealth Occupational Therapy Services	\$25	25%
Telehealth PT and SP Services	\$25	25%
Telehealth Other Health care Providers	\$25	25%
Telehealth Individual Mental Health	\$25	25%
Telehealth Group Mental Health	\$25	25%
Telehealth Individual Psychiatric Services	\$25	25%
Telehealth Group Psychiatric Services	\$25	25%
Telehealth Individual Substance Abuse Services	\$25	25%
Telehealth Group Substance Abuse Services	\$25	25%
Telehealth Kidney Disease Education Services	\$0	25%
Telehealth Diabetes Self-Management Training	\$0	25%
Telehealth Opioid Treatment Program Services	\$25	25%
Telehealth Urgent care	\$25	\$25
Wigs*	\$0	\$0
Maximum	\$400	
Frequency	every year	



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ADDITIONAL SERVICES (NOT COVERED BY ORIGINAL MEDICARE)	This is what you pay for network providers.	This is what you pay for out-of-network providers.
Routine Physical Exams One exam per calendar year	\$0	25%

Benefits that may require a prior authorization are listed with an asterisk (*) in the benefits grid.

See next page for Pharmacy-Prescription Drug Benefits.



PHARMACY - PRESCRIPTION DRUG BENEFITS

Pharmacy Network

P1

Your Medicare Part D plan uses the network above. To find a network pharmacy, you can visit our website (<http://www.aetnaretireeplans.com>.)

Formulary (Drug List)

Classic

Your cost for generic drugs is usually lower than your cost for brand drugs. However, some higher cost generic drugs are combined on brand tiers.

Beginning 1/1/25, the Centers for Medicare Services (CMS) made the following changes to the standard Part D plan design:

- Reduction to three phases - Deductible, Initial Coverage, and Catastrophic
- Elimination of the Initial Coverage Limit and the Coverage Gap Phase
- Introduction of a \$2,000 annual out-of-pocket threshold
- Replacement of the Coverage Gap Discount Program with the Manufacturer Discount Program which will provide a 10% manufacturer discount for brand drugs in the Initial Coverage phase and 20% manufacturer discount for brand drugs in the Catastrophic phase

See below for your specific benefits and cost sharing.

Calendar-Year Deductible for Prescription Drugs \$0

Prescription drug calendar year deductible must be satisfied before any Medicare Prescription Drug benefits are paid. Covered Medicare Prescription Drug expenses will accumulate toward the pharmacy deductible. The deductible does not apply to covered insulins and most Part D vaccines.

Initial Coverage Phase - The table below represents cost sharing after the deductible, if applicable, has been reached.

5 Tier Plan	30-day Supply through Retail		90-day Supply through Retail or Mail		
	Preferred	Standard	Preferred Retail	Preferred Mail	Standard Retail or Mail
Tier 1 - Preferred Generic Generic Drugs	\$5	\$15	\$15	\$15	\$45



5 Tier Plan	30-day Supply through Retail		90-day Supply through Retail or Mail		
	Preferred	Standard	Preferred Retail	Preferred Mail	Standard Retail or Mail
Tier 2 - Generic Generic Drugs	\$15	\$20	\$45	\$45	\$60
Tier 3 - Preferred Brand Includes some high-cost generic and preferred brand drugs	\$40	\$47	\$120	\$120	\$141
Tier 4 - Non-Preferred Drug Includes some high-cost generic and non-preferred brand drugs	\$75	\$100	\$225	\$225	\$300
Tier 5 - Specialty Includes high-cost/unique generic and brand drugs	33%	33%	Limited to one-month supply	Limited to one-month supply	Limited to one-month supply

If you reside in a long-term care facility, your cost share is the same as a 30 day supply at a retail pharmacy and you may receive up to a 31 day supply.

You won't pay more than \$35 for a one-month supply or \$105 for up to a three-month supply of each covered insulin product regardless of the cost-sharing tier.

Catastrophic Coverage:

You pay \$0 for covered Part D prescription drugs.

Catastrophic Coverage benefits start once the CMS-determined annual out-of-pocket threshold of \$2,000 for covered Part D prescription drugs is reached.



Requirements:

Precertification

Applies

Step-Therapy

Applies

Medical Disclaimers

For more information about Aetna plans, go to www.AetnaRetireePlans.com or call Member Services toll-free at 1-888-267-2637 (TTY: 711). Hours are 8 a.m. to 9 p.m. EST, Monday through Friday.

Not all PPO Plans are available in all areas

The provider network may change at any time. You will receive notice when necessary.

In case of emergency, you should call 911 or the local emergency hotline. Or you should go directly to an emergency care facility.

The complete list of services can be found in the Evidence of Coverage (EOC). You can request a copy of the EOC by contacting Member Services at 1-888-267-2637 (TTY: 711). Hours are 8 a.m. to 9 p.m. EST, Monday through Friday.

The following is a partial list of what isn't covered or limits to coverage under this plan:

- Services that are not medically necessary unless the service is covered by Original Medicare or otherwise noted in your Evidence of Coverage
- Plastic or cosmetic surgery unless it is covered by Original Medicare
- Custodial care
- Experimental procedures or treatments that Original Medicare doesn't cover
- Outpatient prescription drugs unless covered under Original Medicare Part B

You may pay more for out-of-network services. Prior approval from Aetna is required for some network services. For services from a non-network provider, prior approval from Aetna is recommended. Providers must be licensed and eligible to receive payment under the federal Medicare program and willing to accept the plan.

Out-of-network/non-contracted providers are under no obligation to treat Aetna members, except in emergency situations. Please call our Customer Service number or see your Evidence of Coverage



for more information, including the cost-sharing that applies to out-of-network services.

Aetna will pay any non contracted provider (that is eligible for Medicare payment and is willing to accept the Aetna Medicare Plan) the same as they would receive under Original Medicare for Medicare covered services under the plan.

Pharmacy Disclaimers

Aetna's retiree pharmacy coverage is an enhanced Part D Employer Group Waiver Plan that is offered as a single integrated product. The enhanced Part D plan consists of two components: basic Medicare Part D benefits and supplemental benefits. Basic Medicare Part D benefits are offered by Aetna based on our contract with CMS. We receive monthly payments from CMS to pay for basic Part D benefits. Supplemental benefits are non-Medicare benefits that provide enhanced coverage beyond basic Part D. Supplemental benefits are paid for by plan sponsors or members and may include benefits for non-Part D drugs. Aetna reports claim information to CMS according to the source of applicable payment (Medicare Part D, plan sponsor or member).

Aetna's pharmacy network includes limited lower-cost, preferred pharmacies in Suburban Arizona, Suburban Illinois, Urban Kansas, Rural Michigan, Urban Michigan, Urban Missouri, Urban Pennsylvania, Suburban Utah, Suburban West Virginia, Suburban Wyoming. The lower costs advertised in our plan materials for these pharmacies may not be available at the pharmacy you use. For up-to-date information about our network pharmacies, including whether there are any lower-cost preferred pharmacies in your area, please call 1-866-241-0357 (TTY: 711) or consult the online pharmacy directory at <http://www.aetnaretireeplans.com>.

The formulary and/or pharmacy network may change at any time. You will receive notice when necessary.

You must use network pharmacies to receive plan benefits except in limited, non-routine circumstances as defined in the EOC. In these situations, you are limited to a 30 day supply.

Pharmacy clinical programs such as precertification, step therapy and quantity limits may apply to your prescription drug coverage.

Members who get "extra help" don't need to fill prescriptions at preferred network pharmacies to get Low Income Subsidy (LIS) copays.

Specialty pharmacies fill high-cost specialty drugs that require special handling. Although specialty pharmacies may deliver covered medicines through the mail, they are not considered "mail-order



pharmacies.” Therefore, most specialty drugs are not available at the mail-order cost share.

The typical number of business days after the mail order pharmacy receives an order to receive your shipment is up to 10 days. Enrollees have the option to sign up for automated mail order delivery. If your mail order drugs do not arrive within the estimated time frame, please contact us toll-free at 1-866-241-0357, 24 hours a day, 7 days a week. TTY users call 711.

There are three general rules about drugs that Medicare drug plans will not cover under Part D. This plan cannot:

- Cover a drug that would be covered under Medicare Part A or Part B.
- Cover a drug purchased outside the United States and its territories.
- Generally cover drugs prescribed for “off label” use, (any use of the drug other than indicated on a drug's label as approved by the Food and Drug Administration) unless supported by criteria included in certain reference books like the American Hospital Formulary Service Drug Information, the DRUGDEX Information System and the USPDI or its successor.

Additionally, by law, the following categories of drugs are not normally covered by a Medicare prescription drug plan unless we offer enhanced drug coverage for which additional premium may be charged. These drugs are not considered Part D drugs and may be referred to as “exclusions” or “non-Part D drugs”. These drugs include:

- Drugs used for the treatment of weight loss, weight gain or anorexia
- Drugs used for cosmetic purposes or to promote hair growth
- Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations
- Outpatient drugs that the manufacturer seeks to require that associated tests or monitoring services be purchased exclusively from the manufacturer as a condition of sale
- Drugs used to promote fertility
- Drugs used to relieve the symptoms of cough and colds
- Non-prescription drugs, also called over-the-counter (OTC) drugs
- Drugs when used for the treatment of sexual or erectile dysfunction

Plan Disclaimers

Aetna Medicare is a HMO and PPO plan with a Medicare contract. Enrollment in our plans depends on contract renewal.

Plans are offered by Aetna Health Inc., Aetna Health of California Inc., Aetna Life Insurance



Company and/or their affiliates (Aetna). Participating physicians, hospitals and other health care providers are independent contractors and are neither agents nor employees of Aetna. The availability of any particular provider cannot be guaranteed, and provider network composition is subject to change.

See Evidence of Coverage for a complete description of plan benefits, exclusions, limitations and conditions of coverage. Plan features and availability may vary by service area.

The formulary, provider and/or pharmacy network may change at any time. You will receive notice when necessary.

Resources For Living is the brand name used for products and services offered through the Aetna group of subsidiary companies.

If there is a difference between this document and the Evidence of Coverage (EOC), the EOC is considered correct.

You can read the *Medicare & You 2026* Handbook. Every year in the fall, this booklet is mailed to people with Medicare. It has a summary of Medicare benefits, rights and protections, and answers to the most frequently asked questions about Medicare. If you don't have a copy of this booklet, you can get it at the Medicare website (<http://www.medicare.gov>) or by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

ATTENTION: If you speak another language, language assistance services, free of charge, are available to you. Call 1-888-267-2637 (TTY: 711). Spanish: ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-888-267-2637 (TTY: 711).

Traditional Chinese: 注意：如果您使用中文，您可以免費獲得語言援助服務。請致電 1-888-267-2637 (TTY: 711).

You can also visit our website at <http://www.aetnaretireeplans.com>. As a reminder, our website has the most up-to-date information about our provider network (Provider Directory) and our list of covered drugs (Formulary/Drug List).

English: We have free interpreter services to answer any questions you may have about our health or drug plan. To get an interpreter, just call us at 1-800-307-4830. Someone who speaks English/Language can help you. This is a free service.

Spanish: Tenemos servicios de intérprete sin costo alguno para responder cualquier pregunta que pueda tener sobre nuestro plan de salud o medicamentos. Para hablar con un intérprete, por favor



llame al 1-800-307-4830. Alguien que hable español le podrá ayudar. Este es un servicio gratuito.

Chinese Mandarin: 我们提供免费的翻译服务，帮助您解答关于健康或药物保险的任何疑问。如果您需要此翻译服务，请致电 1-800-307-4830。我们的中文工作人员很乐意帮助您。这是一项免费服务。

Chinese Cantonese: 您對我們的健康或藥物保險可能存有疑問，為此我們提供免費的翻譯服務。如需翻譯服務，請致電 1-800-307-4830。我們講中文的人員將樂意為您提供幫助。這是一項免費服務。

Tagalog: Mayroon kaming libreng serbisyo sa pagsasaling-wika upang masagot ang anumang mga katanungan ninyo hinggil sa aming planong pangkalusugan o panggamot. Upang makakuha ng tagasaling-wika, tawagan lamang kami sa 1-800-307-4830. Maaari kayong tulungan ng isang nakakapagsalita ng Tagalog. Ito ay libreng serbisyo.

French: Nous proposons des services gratuits d'interprétation pour répondre à toutes vos questions relatives à notre régime de santé ou d'assurance-médicaments. Pour accéder au service d'interprétation, il vous suffit de nous appeler au 1-800-307-4830. Un interlocuteur parlant Français pourra vous aider. Ce service est gratuit.

Vietnamese: Chúng tôi có dịch vụ thông dịch miễn phí để trả lời các câu hỏi về chương sức khỏe và chương trình thuốc men. Nếu quý vị cần thông dịch viên xin gọi 1-800-307-4830 sẽ có nhân viên nói tiếng Việt giúp đỡ quý vị. Đây là dịch vụ miễn phí.

German: Unser kostenloser Dolmetscherservice beantwortet Ihren Fragen zu unserem Gesundheits- und Arzneimittelplan. Unsere Dolmetscher erreichen Sie unter 1-800-307-4830. Man wird Ihnen dort auf Deutsch weiterhelfen. Dieser Service ist kostenlos.

Korean: 당사는 의료 보험 또는 약품 보험에 관한 질문에 답해 드리고자 무료 통역 서비스를 제공하고 있습니다. 통역 서비스를 이용하려면 전화 1-800-307-4830번으로 문의해 주십시오. 한국어를 하는 담당자가 도와 드릴 것입니다. 이 서비스는 무료로 운영됩니다.

Russian: Если у вас возникнут вопросы относительно страхового или медикаментного плана, вы можете воспользоваться нашими бесплатными услугами переводчиков. Чтобы воспользоваться услугами переводчика, позвоните нам по телефону 1-800-307-4830. Вам окажет помощь сотрудник, который говорит по-русски. Данная услуга бесплатная.

:Arabic

إننا نقدم خدمات المترجم الفوري المجانية للإجابة عن أي أسئلة تتعلق بالصحة أو جدول الأدوية لدينا. للحصول على مترجم فوري، ليس عليك سوى الاتصال بنا على 1-800-307-4830. سيقوم شخص ما يتحدث العربية بمساعدتك. هذه خدمة مجانية.



Worthington Enterprises, Inc.
Aetna MedicareSM Plan (PPO)
MA (S02) PPO
Rx RHA R-3

Hindi: हमारे स्वास्थ्य या दवा की योजना के बारे में आपके किसी भी प्रश्न के जवाब देने के लिए हमारे पास मुफ्त दुभाषिया सेवाएँ उपलब्ध हैं। एक दुभाषिया प्राप्त करने के लिए, बस हमें 1-800-307-4830 पर फोन करें। कोई व्यक्ति जो हिन्दी बोलता है आपकी मदद कर सकता है। यह एक मुफ्त सेवा है।

Italian: È disponibile un servizio di interpretariato gratuito per rispondere a eventuali domande sul nostro piano sanitario e farmaceutico. Per un interprete, contattare il numero 1-800-307-4830. Un nostro incaricato che parla Italianovi fornirà l'assistenza necessaria. È un servizio gratuito.

Português: Dispomos de serviços de interpretação gratuitos para responder a qualquer questão que tenha acerca do nosso plano de saúde ou de medicação. Para obter um intérprete, contacte-nos através do número 1-800-307-4830. Irá encontrar alguém que fale o idioma Português para o ajudar. Este serviço é gratuito.

French Creole: Nou genyen sèvis entèprèt gratis pou reponn tout kesyon ou ta genyen konsènan plan medikal oswa dwòg nou an. Pou jwenn yon entèprèt, jis rele nou nan 1-800-307-4830. Yon moun ki pale Kreyòl kapab ede w. Sa a se yon sèvis ki gratis.

Polish: Umożliwiamy bezpłatne skorzystanie z usług tłumacza ustnego, który pomoże w uzyskaniu odpowiedzi na temat planu zdrowotnego lub dawkowania leków. Aby skorzystać z pomocy tłumacza znającego język polski, należy zadzwonić pod numer 1-800-307-4830. Ta usługa jest bezpłatna.

Japanese: 当社の健康 健康保険と薬品 処方薬プランに関するご質問にお答えするために、無料の通訳サービスがあります。通訳をご用命になるには、1-800-307-4830にお電話ください。日本語を話す人 者が支援いたします。これは無料のサービスです。

Hawaiian: He kōkua māhele ‘ōlelo kā mākou i mea e pane ‘ia ai kāu mau nīnau e pili ana i kā mākou papahana olakino a lā‘au lapa‘au paha. I mea e loa‘a ai ke kōkua māhele ‘ōlelo, e kelepona mai iā mākou ma 1-800-307-4830. E hiki ana i kekahi mea ‘ōlelo Pelekānia/‘Ōlelo ke kōkua iā ‘oe. He pōmaika‘i manuahi kēia.

*****This is the end of this plan benefit summary*****

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Retiree Health Access® Program – Non-Medicare Eligible (Pre-65)

	Open Access Managed Choice Standard		Open Access Managed Choice High (HDHP)		Open Access Managed Choice Low (HDHP)		Open Access Managed Choice Value	
	In Network	Out of Network	In Network	Out of Network	In Network	Out of Network	In Network	Out of Network
Annual Deductible (single/family)	\$1,500/\$3,000	\$3,000/\$6,000	\$2,500/\$5,000 ^{5 6}	\$5,000/\$10,000 ^{5 6}	\$3,950/\$7,900 ^{5 6}	\$3,950/\$7,900 ^{5 6}	\$5,750/\$11,500	\$11,500/\$23,000
Annual Out-of-Pocket Maximum Includes annual deductible¹ (single/family)	\$4,000 / \$8,000	\$10,000/\$20,000	\$5,000/\$10,000 ^{5 6}	\$10,000/\$20,000 ^{5 6}	\$6,650/\$13,300 ^{5 6}	\$15,000/\$30,000 ^{5 6}	\$6,650/\$13,300	\$20,000/\$40,000
Plan Coinsurance	20% after deductible	40% after deductible	20% after deductible	40% after deductible	20% after deductible	40% after deductible	30% after deductible	50% after deductible
Lifetime Maximum	\$1.25 million lifetime maximum \$50,000 AYR		\$1.25 million lifetime maximum \$50,000 AYR		\$1.25 million lifetime maximum \$50,000 AYR		\$1.25 million lifetime maximum \$50,000 AYR	
Adult Routine Physical Exam One exam every 24 months Routine Gynecological Exam One gynecological exam per year with one pap smear and related lab fees Routine Mammogram Routine Prostate-Specific Antigen Test (PSA) and Digital Rectal Exam (DRE)	0% coinsurance deductible, copay waived	40% after deductible	0%, deductible waived	40% after deductible	0%, deductible waived	40% after deductible	0%, deductible waived	50% after deductible
Routine Eye Exam one exam every 24 months	0% after \$50 specialist copay	40% after deductible	0%, no deductible	40% after deductible	0%, no deductible	40% after deductible	0%, no deductible	50% after deductible
Routine Hearing Exam one exam every 24 months	0% after \$50 specialist copay	40% after deductible	0%, no deductible	40% after deductible	0%, no deductible	40% after deductible	0%, no deductible	50% after deductible
Primary Care Office Visit	\$25 copay	40% after deductible	20% after deductible	40% after deductible	20% after deductible	40% after deductible	30% after deductible	50% after deductible
Specialist Office Visit	0% after-\$50 copay	40% after deductible	20% after deductible	40% after deductible	20% after deductible	40% after deductible	30% after deductible	50% after deductible
Outpatient Surgery - surgeon charges	20% after deductible	40% after deductible	20% after deductible	40% after deductible	20% after deductible	40% after deductible	30% after deductible	50% after deductible
Diagnostic X-Ray and Lab As part of an office visit and billed by physician	0%, after office visit copay	40% after deductible	20% after deductible	40% after deductible	20% after deductible	40% after deductible	30% after deductible	50% after deductible
Diagnostic X-Ray and Lab Performed in an outpatient setting	20% after deductible	40% after deductible	20% after deductible	40% after deductible	20% after deductible	40% after deductible	30% after deductible	50% after deductible
Complex Imaging Services MRA/MRS, MRI, CT Scan, PET Scan	20% after deductible	40% after deductible	20% after deductible	40% after deductible	20% after deductible	40% after deductible	30% after deductible	50% after deductible
Emergency Room Visit	0% after \$200 copay	0% after \$200 copay	20% after deductible	20% after deductible	20% after deductible	20% after deductible	30% after deductible	30% after deductible
Application of Plan Deductible to Emergency Room Expenses	N/A		Plan deductible applies; then coinsurance		Plan deductible applies; then coinsurance		Plan deductible applies; then coinsurance	
Urgent Care	0% after \$75 copay	40% after deductible	20% after deductible	40% after deductible	20% after deductible	40% after deductible	30% after deductible	50% after deductible
Ambulance	20% after deductible	20% after deductible	20% after deductible	20% after deductible	20% after deductible	20% after deductible	30% after deductible	30% after deductible
Hospital Room and Board	20% after deductible	40% after deductible	20% after deductible	40% after deductible	20% after deductible	40% after deductible	30% after deductible	50% after deductible
Skilled Nursing (maximum 60 days per year)	20% after deductible	40% after deductible	20% after deductible	40% after deductible	20% after deductible	40% after deductible	30% after deductible	50% after deductible
Home Health (maximum 120 days per year)	20% after deductible	40% after deductible	20% after deductible	40% after deductible	20% after deductible	40% after deductible	30% after deductible	50% after deductible
Durable Medical Equipment/Prosthetics (\$10,000 annual maximum)	20% after deductible	40% after deductible	20% after deductible	40% after deductible	20% after deductible	40% after deductible	30% after deductible	50% after deductible
Chiropractic Care	0% after \$50 specialist copay ³	40% after deductible	20% after deductible	40% after deductible	20% after deductible	40% after deductible	30% after deductible	50% after deductible
Retail Rx Copay (preferred generic / preferred brand / non preferred generic & brand) ^{2 7}	10% 20%/\$50 max ⁴ 50%/\$150 max ⁴	40% after applicable in-network retail copay	10%-25%-50% after annual deductible		10%-25%-50% after annual deductible		10%-25%-50% after annual deductible	
Mail-Order Rx Copay (preferred generic / preferred brand / non preferred generic & brand) ^{2 7}	10% 20%/\$100 max ⁴ 50%/\$300 max	Not applicable	10%-25%-50% after annual deductible	Not applicable	10%-25%-50% after annual deductible	Not applicable	10%-25%-50% after annual deductible	Not applicable
Monthly Premiums	Single: \$2,606.35 Family: \$5,261.98		Single: \$2,104.63 Family: \$4,248.41		Single: \$1,618.62 Family: \$3,266.35		Single: \$1,213.96 Family: \$2,449.77	

▪ **Plan designs reflect the retiree's cost-sharing. State mandates may apply.**

- ¹ Copays do not reduce the out-of-pocket maximums.
- ² Member pays the difference in cost between a brand and generic drug, in addition to their copayment or coinsurance, if a generic drug is available but a brand drug is dispensed.
- ³ If rendered in a physician's office, otherwise plan coinsurance applies after deductible.
- ⁴ The pharmacy coinsurance copay is subject to a maximum (as noted) per prescription for preferred brand and non preferred generic & brand.
- ⁵ Amounts intended to be the minimum deductible and out-of-pocket limits required under current law for a high-deductible health plan (HDHP) to qualify an individual as eligible to contribute to an HSA. If other than single coverage, family deductible must be met before the plan will pay.
- ⁶ Amounts intended to be the maximum deductible and out-of-pocket limits required under current law for a high-deductible health plan (HDHP) to qualify an individual as eligible to contribute to an HSA. If other than single coverage, family deductible must be met before the plan will pay. If other than single coverage, family out of pocket limit must be met before the plan pays at 100%.
- ⁷ Step Therapy and Precert applies. Specialty Drugs included, require use of Specialty Network.

Providers are independent contractors and are not agents of Aetna. Provider participation may change without notice. Aetna does not provide care or guarantee access to health services.

Refer to **Aetna.com** for more information.

CVS Caremark® Mail Service Pharmacy and Aetna are part of the CVS Health family of companies. Aetna, or its affiliate(s), receives rebates from drug manufacturers that may be taken into account in determining Aetna's drug lists. Rebates may reduce the amount a member pays the pharmacy for covered prescriptions. For a complete list of other participating pharmacies, log in to Aetna.com and use our provider search tool.

Product availability may vary by state.

Retiree Health Access® and RHA® are registered trademarks of Health Care Roundtable, LLC, used under license with Health Care Policy Roundtable. All rights reserved. Aetna reserves the right to change or terminate benefits at any time, to the extent permitted by law.

If you require language assistance, please call the Member Services number on your Aetna ID card, and an Aetna representative will connect you with an interpreter. If you're deaf or hard of hearing, use your TTY and dial 711 for the Telecommunications Relay Service. Once connected, please enter or provide the Aetna telephone number you're calling.

Si usted necesita asistencia lingüística, por favor llame al número de Servicios al Miembro que figura en su tarjeta de identificación de Aetna, y un representante de Aetna le conectará con un intérprete. Si usted es sordo o tiene problemas de audición, use su TTY y marcar 711 para el Servicio de Retransmisión de Telecomunicaciones (TRS). Una vez conectado, por favor entrar o proporcionar el número de teléfono de Aetna que está llamando.

Aetna complies with applicable Federal civil rights laws and does not discriminate, exclude or treat people differently based on their race, color, national origin, sex, age, or disability.

We provide free aids/services to people with disabilities and to people who need language assistance.

If you need a qualified interpreter, written information in other formats, translation or other services, call the number on your ID card.

If you believe we have failed to provide these services or otherwise discriminated based on a protected class noted above, you can also file a grievance with the Civil Rights Coordinator by contacting:

Civil Rights Coordinator, P.O. Box 14462, Lexington, KY 40512 (CA HMO customers: PO Box 24030 Fresno, CA 93779), 1-800-648-7817, TTY: 711, Fax: 859-425-3379 (CA HMO customers: 860-262-7705), CRCoordinator@Aetna.com.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights Complaint Portal, available at <https://ocrportal.gov/ocr/portal/lobby.jsf>, or at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, or at 1-800-368-1019, 800-537-7697 (TDD).